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: 0047126

Facility Name: St Anthonys Nsg & Rehab Ctr

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

County: Rock Island

Telephone Number: 309.788.7631 **Fax #** 309.788.9823

HFS ID Number:

Date of Initial License for Current Owners: 5/19/2005

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Chris Joos **Telephone Number:** 614.222.9040
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 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) Suzanne Koenig
(Title) Owner

Paid Preparer
(Signed) (Date)
(Print Name and Title) Chris Joos, Partner
(Firm Name & Address) Plante Moran, PLLC, 250 S. High Street, ste 100
(Telephone) 614.222.9040 Fax # 248.233.8811

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

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr # 0047126 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	52	Skilled (SNF)	52	18,980	1
2		Skilled Pediatric (SNF/PED)			2
3	78	Intermediate (ICF)	78	28,470	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	130	TOTALS	130	47,450	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	7,129	3,988	3,746	14,863	8
9	SNF/PED					9
10	ICF	20,015	1,287	167	21,469	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,144	5,275	3,913	36,332	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.57%

D. How many bed reserve days during this year were paid by the Department?
0 (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)
N/A

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES [Y] NO [ ] If YES, enter number of beds certified 52 and days of care provided 2,557

Medicare Intermediary NATIONAL GOVERNMENT SERVICES, INC.

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/18 Fiscal Year: 12/31/18

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

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr # 0047126 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	215,660	18,810	12,982	247,452	0	247,452	0	247,452			1
2	Food Purchase		222,138		222,138	0	222,138	0	222,138			2
3	Housekeeping	195,476	31,657	0	227,133	0	227,133	0	227,133			3
4	Laundry	42,637	32,208	0	74,845	0	74,845	0	74,845			4
5	Heat and Other Utilities			323,832	323,832	0	323,832	(14,183)	309,649			5
6	Maintenance	133,041	121,826	11,725	266,592	0	266,592	1,356	267,948			6
7	Other (specify):* Security & Trash	33,234	0	29,458	62,692	0	62,692	0	62,692			7
8	**TOTAL General Services**	620,048	426,639	377,997	1,424,684	0	1,424,684	(12,827)	1,411,857			8
	B. Health Care and Programs											
9	Medical Director	0	0	25,289	25,289	0	25,289	0	25,289			9
10	Nursing and Medical Records	2,496,604	235,283	17,387	2,749,274	0	2,749,274	41,398	2,790,672			10
10a	Therapy	0	0	606,852	606,852	0	606,852	0	606,852			10a
11	Activities	44,967	3,602	0	48,569	0	48,569	0	48,569			11
12	Social Services	31,078	0	13,005	44,083	0	44,083	0	44,083			12
13	CNA Training	0	0	0	0	0	0	0	0			13
14	Program Transportation	0	0	7,880	7,880	0	7,880	0	7,880			14
15	Other (specify):*	0	0	0	0	0	0	0	0			15
16	**TOTAL Health Care and Programs**	2,572,649	238,885	670,413	3,481,947	0	3,481,947	41,398	3,523,345			16
	C. General Administration											
17	Administrative	98,488	0	315,004	413,492	0	413,492	(261,490)	152,002			17
18	Directors Fees			0	0	0	0	0	0			18
19	Professional Services			157,917	157,917	0	157,917	53,038	210,955			19
20	Dues, Fees, Subscriptions & Promotions			59,542	59,542	0	59,542	11,286	70,828			20
21	Clerical & General Office Expenses	138,043	36,380	173,746	348,169	0	348,169	(46,827)	301,342			21
22	Employee Benefits & Payroll Taxes			362,541	362,541	0	362,541	40,560	403,101			22
23	Inservice Training & Education			0	0	0	0	0	0			23
24	Travel and Seminar			10,912	10,912	0	10,912	24,134	35,046			24
25	Other Admin. Staff Transportation		0	0	0	0	0	0	0			25
26	Insurance-Prop.Liab.Malpractice			169,559	169,559	0	169,559	58,696	228,255			26
27	Other (specify):* Marketing	48,053	0	5,632	53,685	0	53,685	(53,685)	0			27
28	**TOTAL General Administration**	284,584	36,380	1,254,853	1,575,817	0	1,575,817	(174,288)	1,401,529			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,477,281	701,904	2,303,263	6,482,448	0	6,482,448	(145,717)	6,336,731			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.

St Anthonys Nsg & Rehab Ctr
Medicaid Cost Report
1/1/18 - 12/31/18

Page 3 Supplemental Schedule

MCDACT	LIENT_AC	DESC	BALANCE	DESC	PG 3 REFERENCE
7625.10	6431.00	Plant Security-Payroll	29,458.39	Security Services Salary	V07-1
7520.00	6460.00	Plant-Trash Removal	33,233.77	Trash and Refuse Removal	V07-3
			62,692.16		
			62,692.00	**PG 3, LINE 7, COLUMN 8**	
			0.16	*Rounding*	

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr #0047126 Report Period Beginning: 1/1/18 Ending: 12/31/18

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			20,675	20,675	0	20,675	378,742	399,417			30
31	Amortization of Pre-Op. & Org.			0	0	0	0	0	0			31
32	Interest			76,368	76,368	0	76,368	524,295	600,663			32
33	Real Estate Taxes			0	0	0	0	80,060	80,060			33
34	Rent-Facility & Grounds			1,068,000	1,068,000	0	1,068,000	(1,052,523)	15,477			34
35	Rent-Equipment & Vehicles			8,038	8,038	0	8,038	10	8,048			35
36	Other (specify):* Mortgage Ins.			0	0	0	0	39,752	39,752			36
37	TOTAL Ownership			1,173,081	1,173,081	0	1,173,081	(29,664)	1,143,417			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0			38
39	Ancillary Service Centers	0	20,293	112,260	132,553	0	132,553	0	132,553			39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0			40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0			41
42	Provider Participation Fee	0	0	282,927	282,927	0	282,927	0	282,927			42
43	Other (specify):*	0	0	0	0	0	0	0	0			43
44	TOTAL Special Cost Centers	0	20,293	395,187	415,480	0	415,480	0	415,480			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,477,281	722,197	3,871,531	8,071,009	0	8,071,009	(175,381)	7,895,628			45

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

St Anthonys Nsg & Rehab Ctr
Medicaid Cost Report
1/1/18 - 12/31/18

Page 4 Supplemental Schedule

MCDACT	CLIENT_ACT	DESC	BALANCE	DESC	PG 4 REFERENCE
N/A	SAPP Related Party Account	Mortgage Insurance	39,751.74	Mortgage Insurance	V36-7
			39,752.00	**PG 4, LINE 36, COLUMN 8**	
			(0.26)	*Rounding*	

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr # 0047126 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	$ 0		$	1
2	Other Care for Outpatients	0			2
3	Governmental Sponsored Special Programs	0			3
4	Non-Patient Meals	0	2		4
5	Telephone, TV & Radio in Resident Rooms	(14,876)	5		5
6	Rented Facility Space	0			6
7	Sale of Supplies to Non-Patients	0			7
8	Laundry for Non-Patients	0			8
9	Non-Straightline Depreciation	0			9
10	Interest and Other Investment Income	0			10
11	Discounts, Allowances, Rebates & Refunds	0			11
12	Non-Working Officer's or Owner's Salary	0			12
13	Sales Tax	0			13
14	Non-Care Related Interest	0			14
15	Non-Care Related Owner's Transactions	0			15
16	Personal Expenses (Including Transportation)	0			16
17	Non-Care Related Fees	0			17
18	Fines and Penalties	(72,957)	21		18
19	Entertainment	0			19
20	Contributions	0			20
21	Owner or Key-Man Insurance	0			21
22	Special Legal Fees & Legal Retainers	0			22
23	Malpractice Insurance for Individuals	0			23
24	Bad Debt	(71,316)	21		24
25	Fund Raising, Advertising and Promotional	(53,685)	27		25
26	Income Taxes and Illinois Personal Property Replacement Tax	0			26
27	CNA Training for Non-Employees	0			27
28	Yellow Page Advertising	0			28
29	Other-Attach Schedule	(5,010)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (217,844)		$ 0	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*	$ 0	0	31
32	Donated Goods-Attach Schedule*	0	0	32
33	Amortization of Organization & Pre-Operating Expense	0	0	33
34	Adjustments for Related Organization Costs (Schedule VII)	42,463	VII-B	34
35	Other- Attach Schedule	0		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 42,463		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (175,381)		37

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

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

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

St Anthonys Nsg & Rehab Ctr

ID# 0047126

Report Period Beginning: 1/1/18

Ending: 12/31/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Independent Living	$ 0	43	1
2	Non-Allowable Benefits (Marketing & ILU)	(5,010)	22	2
3	Non-Allowable Costs	0	43	3
4		0		4
5		0		5
6		0		6
7		0		7
8		0		8
9		0		9
10		0		10
11		0		11
12		0		12
13		0		13
14		0		14
15		0		15
16		0		16
17		0		17
18		0		18
19		0		19
20		0		20
21		0		21
22		0		22
23		0		23
24		0		24
25		0		25
26		0		26
27		0		27
28		0		28
29		0		29
30		0		30
31		0		31
32		0		32
33		0		33
34		0		34
35		0		35
36		0		36
37		0		37
38		0		38
39		0		39
40		0		40
41		0		41
42		0		42
43		0		43
44		0		44
45		0		45
46		0		46
47		0		47
48		0		48
49	**Total**	(5,010)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr # 0047126 Report Period Beginning: 1/1/18 Ending: 12/31/18

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(14,876)	0	693	0	0	0	0	0	0	0	0	(14,183)	5
6	Maintenance	0	0	1,356	0	0	0	0	0	0	0	0	1,356	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(14,876)	0	2,049	0	0	0	0	0	0	0	0	(12,827)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	41,398	0	0	0	0	0	0	0	0	41,398	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	41,398	0	0	0	0	0	0	0	0	41,398	16
	C. General Administration													
17	Administrative	0	0	(261,490)	0	0	0	0	0	0	0	0	(261,490)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	21,150	31,888	0	0	0	0	0	0	0	0	53,038	19
20	Fees, Subscriptions & Promotions	0	0	11,286	0	0	0	0	0	0	0	0	11,286	20
21	Clerical & General Office Expenses	(144,273)	2,575	94,871	0	0	0	0	0	0	0	0	(46,827)	21
22	Employee Benefits & Payroll Taxes	(5,010)	0	45,570	0	0	0	0	0	0	0	0	40,560	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	24,134	0	0	0	0	0	0	0	0	24,134	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	49,970	8,726	0	0	0	0	0	0	0	0	58,696	26
27	Other (specify):*	(53,685)	0	0	0	0	0	0	0	0	0	0	(53,685)	27
28	**TOTAL General Administration**	(202,968)	73,695	(45,015)	0	0	0	0	0	0	0	0	(174,288)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(217,844)	73,695	(1,568)	0	0	0	0	0	0	0	0	(145,717)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr # 0047126 Report Period Beginning: 1/1/18 Ending: 12/31/18

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	0	374,993	3,749	0	0	0	0	0	0	0	0	378,742	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	524,295	0	0	0	0	0	0	0	0	0	524,295	32
33	Real Estate Taxes	0	80,060	0	0	0	0	0	0	0	0	0	80,060	33
34	Rent-Facility & Grounds	0	(1,068,000)	15,477	0	0	0	0	0	0	0	0	(1,052,523)	34
35	Rent-Equipment & Vehicles	0	0	10	0	0	0	0	0	0	0	0	10	35
36	Other (specify):*	0	39,752	0	0	0	0	0	0	0	0	0	39,752	36
37	TOTAL Ownership	0	(48,900)	19,236	0	0	0	0	0	0	0	0	(29,664)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(217,844)	24,795	17,668	0	0	0	0	0	0	0	0	(175,381)	45

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr # 0047126 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6 - Supp		See Page 6 - Supp		See Page 6 - Supp		

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 1,068,000	St. Anthony's Property Partners, LLC	100.00%	$	$ (1,068,000)	1
2	V	19	Professional Fees		St. Anthony's Property Partners, LLC	100.00%	21,150	21,150	2
3	V	21	Office and Clerical		St. Anthony's Property Partners, LLC	100.00%	2,575	2,575	3
4	V	26	Property Insurance		St. Anthony's Property Partners, LLC	100.00%	49,970	49,970	4
5	V	30	Depreciation		St. Anthony's Property Partners, LLC	100.00%	374,993	374,993	5
6	V	32	Amortization		St. Anthony's Property Partners, LLC	100.00%	24,574	24,574	6
7	V	32	Interest		St. Anthony's Property Partners, LLC	100.00%	499,722	499,722	7
8	V	33	Real Estate Taxes		St. Anthony's Property Partners, LLC	100.00%	80,060	80,060	8
9	V	36	Mortgage Insurance		St. Anthony's Property Partners, LLC	100.00%	39,752	39,752	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,068,000			$ 1,092,795	$ * 24,795	14

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

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr # 0047126 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	6	Maintenance	$	SAK Management Services, LLC	100.00%	$ 1,356	$ 1,356	15
16	V	10	Nursing		SAK Management Services, LLC	100.00%	41,398	41,398	16
17	V	17	Administration	315,004	SAK Management Services, LLC	100.00%	53,514	(261,490)	17
18	V	19	Professional Fees		SAK Management Services, LLC	100.00%	31,888	31,888	18
19	V	20	Dues and Subscriptions		SAK Management Services, LLC	100.00%	11,286	11,286	19
20	V	21	Office and Clerical		SAK Management Services, LLC	100.00%	94,871	94,871	20
21	V	22	Employee Benefits		SAK Management Services, LLC	100.00%	45,570	45,570	21
22	V	24	Seminar and Education		SAK Management Services, LLC	100.00%	24,134	24,134	22
23	V	26	Insurance		SAK Management Services, LLC	100.00%	8,726	8,726	23
24	V	30	Depreciation		SAK Management Services, LLC	100.00%	3,749	3,749	24
25	V								25
26	V	34	Rent - Building		SAK Management Services, LLC	100.00%	15,477	15,477	26
27	V	35	Rent - Equipment		SAK Management Services, LLC	100.00%	10	10	27
28	V	5	Heat and Other Utilities		SAK Management Services, LLC	100.00%	693	693	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			$ 315,004			$ 332,672	$ * 17,668	39

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

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr # 0047126 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr # 0047126 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr # 0047126 Report Period Beginning: 1/1/2018 Ending: ######

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr # 0047126 Report Period Beginning: 1/1/2018 Ending: ######

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		SEE EXHIBIT 2 - SAK MANAGEMENT SERVICES ALLOCATIONS				$	$		$	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					$	$		$ 0	25

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr # 0047126 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	HUD		X	Mortgage	$86,884.57	9/17/12	$ 11,995,400	$ 10,588,613	1/1/2048	4.5000	$ 524,295	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Bank Leumi		X	Line of Credit				504,177			48,814	6
7	Monroe Capital		X	Line of Credit				186,449			27,967	7
8												8
9	TOTAL Facility Related				$86,884.57		$ 11,995,400	$ 11,279,239			$ 601,077	9
	B. Non-Facility Related*											
10	Interest Income Offset										(414)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 0	$ 0			$ (414)	14
15	TOTALS (line 9+line14)						$ 11,995,400	$ 11,279,239			$ 600,663	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 39,752 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 St Anthonys Nsg & Rehab Ctr # 0047126 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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.**	$	84,063	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.)	$	83,018	2
3. Under or (over) accrual (line 2 minus line 1).	$	(1,045)	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)	$	81,105	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	80,060	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	80,326	8
	2014	79,152	9
	2015	76,767	10
	2016	82,234	11
	2017	84,063	12

Estimated roughly 3% increase from taxes paid during the year

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 St Anthonys Nsg & Rehab Ctr COUNTY Rock Island

FACILITY IDPH LICENSE NUMBER 0047126

CONTACT PERSON REGARDING THIS REPORT Chris Joos

TELEPHONE 614.222.9040 FAX #: 248.233.8811

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.	07-364-21-002	Long Term Care Facility	$ 7,674.40	$ 7,674.40
2.	07-364-21-001	Long Term Care Facility	$ 73,828.00	$ 73,828.00
3.	07-363-55-002	Long Term Care Facility	$ 1,515.60	$ 1,515.60
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 83,018.00	$ 83,018.00

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 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 St Anthonys Nsg & Rehab Ctr # 0047126 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr # 0047126 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	130		2005		$ 2,050,000	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13	Various			2011	12,075						13
14	Water Heater			2013	16,698						14
15	Fire Protection System			2014	26,285						15
16	Boiler Pump - Parts and Repairs			2014	3,963						16
17	Fire Panel			2016	4,936						17
18	Door and Knob Hardware			2016	5,196						18
19	Sliding/Kithen/Fire Door			2017	6,748						19
20	Basement electrical panel			2017	4,936						20
21	Water Heaters/Boilers			2017	78,601						21
22	Parking Lot Sink Hole			2017	6,727						22
23	Fire Sprinkler			2017	1,804						23
24	Servewell Buffet			2017	3,226						24
25											25
26											26
27	St. Anthony's Property Partners, LLC										27
28											28
29	Complete Facility Rehabilitation and Renovation			2012	6,510,694						29
30	Complete Facility Rehabilitation and Renovation			2013	1,200,533						30
31	Chiller			2016	127,850						31
32											32
33											33
34											34
35											35
36											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 St Anthonys Nsg & Rehab Ctr # 0047126 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			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Depreciation - St. Anthony's Nursing & Rehab Ctr, LLC			5,108		5,108		5,108	67
68	Depreciation - St. Anthony's Property Partners, LLC			312,946		312,946		2,850,358	68
69	Depreciation - SAK Management Services, Inc.			3,749		3,749		4,470	69
70	TOTAL (lines 4 thru 69)		$ 10,060,272	$ 321,803		$ 321,803	$ 0	$ 2,859,936	70

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

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr # 0047126 Report Period Beginning: 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	$ 394,725	$ 23,612	$ 23,612	$ 0		$ 390,617	71
72	Current Year Purchases	7,360	82	82	0		164	72
73	Fully Depreciated Assets				0			73
74	See Supplemental Schedule	710,291	52,420	52,420	0		364,175	74
75	TOTALS	$ 1,112,376	$ 76,114	$ 76,114	$ 0		$ 754,956	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	Ford Windstar	2005	$ 1,506	$	$	$ 0	7	$ 1,506	76
77	Facility	Snow Plow Truck	2010	5,500			0	7	5,500	77
78	Facility	Ford E 350 Bus	2014	15,623	1,500	1,500	0	5	15,623	78
79							0			79
80	TOTALS			$ 22,629	$ 1,500	$ 1,500	$ 0		$ 22,629	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 11,350,277	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 399,417	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 399,417	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 0	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,637,521	85	

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

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

G. Construction-in-Progress

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

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

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

St Anthonys Nsg & Rehab Ctr
Medicaid Cost Report
1/1/18 - 12/31/18

Page 13 Supplemental Schedule

	Class	Cost	Depreciation	Accum
St. Anthony's Property Partners, LLC	Furniture & Equipment	710,291	52,420	364,175
		710,291	52,420	364,175

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr # 0047126 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							4
5	SAK Management				15,477			5
6								6
7	TOTAL				$ 15,477 **			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: $ 8,038 Description: See Supplemental Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

St Anthonys Nsg & Rehab Ctr
Medicaid Cost Report
1/1/18 - 12/31/18

Page 14 Supplemental Schedule

MCDACT	CLIENT_ACT	DESC	BALANCE	DESC	PG 14 REFERENCE
8065	7040	Rent-Equipment	6,438.28	Lease and Rent - Equipment	V35-3
8065	7020	Auto Expense	1,599.32	Lease and Rent - Equipment	V35-3
N/A	6170 · Equipment Rental	SAK Management Services, Inc.	10.00	Equipment Rental	V35-7
			8,047.60		
			8,048.00	PG 14, LINE 35, COLUMN 8	
			(0.40)	Rounding	

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr # 0047126 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

   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 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$	$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	CNA Competency Tests				0
9	TOTALS	$ 0	$ 0	$ 0	$ 0
10	SUM OF line 9, col. 1 and 2 (e)	$ 0			

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 St Anthonys Nsg & Rehab Ctr # 0047126 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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

	1	2		3	4		5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	V10A	0.00	hrs	$ 0	2,718	$ 223,222	$ 0	2,718	$ 223,222	1
2	Licensed Speech and Language Development Therapist	V10A	0.00	hrs	0	218	24,388	0	218	24,388	2
3	Licensed Recreational Therapist	V10A	0.00	hrs	0	0	0	0			3
4	Licensed Physical Therapist	V10A	0.00	hrs	0	4,254	359,242	0	4,254	359,242	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation	V39	0.00	hrs	0	0	0	0			8
9	Pharmacy	V39	0.00	# of prescrpts	0	0	0	96,797		96,797	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): LAB/RADIOLOGY	V39	0.00		0	0	0	15,464		15,464	12
13	Other (specify): BILLABLE SUPPLIES	V39	0.00		0	0	0	20,292		20,292	13
14	TOTAL				$	7,190	$ 606,852	$ 132,553	7,190	$ 739,405	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 St Anthonys Nsg & Rehab Ctr # 0047126 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	$ 63,792	$ 50,503	1
2	Cash-Patient Deposits	58,307	58,307	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 561,343)	1,509,646	2,048,646	3
4	Supply Inventory (priced at)	0		4
5	Short-Term Investments	0		5
6	Prepaid Insurance	0	68,915	6
7	Other Prepaid Expenses	152,251	152,251	7
8	Accounts Receivable (owners or related parties)	0		8
9	Other(specify): See Supplemental Schedule	8,492	321,215	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,792,488	$ 2,699,837	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	0		11
12	Long-Term Investments	0		12
13	Land	0	155,000	13
14	Buildings, at Historical Cost	133,829	10,060,271	14
15	Leasehold Improvements, at Historical Cost	0		15
16	Equipment, at Historical Cost	424,715	1,135,006	16
17	Accumulated Depreciation (book methods)	(413,999)	(3,637,521)	17
18	Deferred Charges	0		18
19	Organization & Pre-Operating Costs	0		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	0		20
21	Restricted Funds	0		21
22	Other Long-Term Assets (specify):	0		22
23	Other(specify): See Supplemental Schedule	0	131,869	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 144,545	$ 7,844,625	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,937,033	$ 10,544,462	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 7,116,350	$ 7,227,547	26
27	Officer's Accounts Payable	0		27
28	Accounts Payable-Patient Deposits	51,743	51,743	28
29	Short-Term Notes Payable	690,626	690,626	29
30	Accrued Salaries Payable	263,039	263,039	30
31	Accrued Taxes Payable (excluding real estate taxes)	(7,342)	(7,342)	31
32	Accrued Real Estate Taxes(Sch.IX-B)	0	81,105	32
33	Accrued Interest Payable	0	763,554	33
34	Deferred Compensation	0		34
35	Federal and State Income Taxes	0		35
	Other Current Liabilities(specify):			
36		0		36
37		0		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 8,114,416	$ 9,070,272	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	0		39
40	Mortgage Payable	0	11,279,239	40
41	Bonds Payable	0		41
42	Deferred Compensation	0		42
	Other Long-Term Liabilities(specify):			
43		0		43
44	See Supplemental Schedule	361,515	(10,717)	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 361,515	$ 11,268,522	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 8,475,931	$ 20,338,794	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (6,538,898)	$ (9,794,332)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,937,033	$ 10,544,462	48

*(See instructions.)

St Anthonys Nsg & Rehab Ctr
Medicaid Cost Report
1/1/18 - 12/31/18

Page 17 Supplemental Schedule

MCDACT	CLIENT_ACT	DESC	BALANCE	DESC	PG 17 REFERENCE
1070.1	1300	Refunds Due/Clearing Acct	8,492.25	Other Receivables	Line 9
SAPP	112.0	Replacement Reserve Escrow	340,124.86	Escrow Account	Line 9
SAPP	112.6	REAL ESTATE ESCROW DEPOSIT	(109,119.76)	Escrow Account	Line 9
SAPP	112.7	MIP Insurance Escrow	(34,072.79)	Escrow Account	Line 9
SAPP	112.8	Insurance Escrow	115,790.49	Escrow Account	Line 9
			321,215.05		
			$ 0	tie out to PG17, s/b 0	
SAPP	119.0	Loan Issuance Costs	131,869	Loan Costs	Line 23
			$ -	tie out to PG17, s/b 0	
2430	5250	Due to SAPP	(192,130.59)	Related Party Loans - Int. Non-Allowable	Line 44
2430	5443	Note Payable - Suzy Koenig	(169,386.00)	Related Party Loans - Int. Non-Allowable	Line 44
2430	5500	Due to SAK MGMT	-	Related Party Loans - Int. Non-Allowable	Line 44
2430	PM 11710	Due to SAPP	-	Related Party Loans - Int. Non-Allowable	Line 44
	1130	Tenant/Member accounts receivab	857,785.00	Related Party Receivable/Payable	Line 44
	114.8	Due from St. Anthony's Nrg&Reha	248,579.59	Related Party Receivable/Payable	Line 44
	114.9	Allowance for D/A	(734,130.59)	Related Party Receivable/Payable	Line 44
	PM 2110	Due to St. Anthony's Nursing	-	Related Party Receivable/Payable	Line 44
			10,717.41		
			0	tie out to PG17, s/b 0	

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr # 0047126 Report Period Beginning: ###### Ending: 12/31/2018

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (5,466,531)	1
2	Restatements (describe):		2
3	0	0	3
4	0	0	4
5	0	0	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (5,466,531)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(920,600)	7
8	Aquisitions of Pooled Companies	0	8
9	Proceeds from Sale of Stock	0	9
10	Stock Options Exercised	0	10
11	Contributions and Grants	0	11
12	Expenditures for Specific Purposes	0	12
13	Dividends Paid or Other Distributions to Owners	(0)	13
14	Donated Property, Plant, and Equipment	0	14
15	Other (describe) 0	0	15
16	Other (describe) 0	0	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (920,600)	17
	B. Transfers (Itemize):		
18	**ILU net asset activity for the year**	(151,767)	18
19	0	0	19
20	0	0	20
21	0	0	21
22	0	0	22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (151,767)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (6,538,898)	24 *

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

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr # 0047126 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	$ 5,942,468	1
2	Discounts and Allowances for all Levels	(419,560)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,522,908	3
	B. Ancillary Revenue		
4	Day Care	0	4
5	Other Care for Outpatients	0	5
6	Therapy	1,519,077	6
7	Oxygen	0	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,519,077	8
	C. Other Operating Revenue		
9	Payments for Education	0	9
10	Other Government Grants	0	10
11	CNA Training Reimbursements	0	11
12	Gift and Coffee Shop	0	12
13	Barber and Beauty Care	0	13
14	Non-Patient Meals	0	14
15	Telephone, Television and Radio	0	15
16	Rental of Facility Space	0	16
17	Sale of Drugs	101,006	17
18	Sale of Supplies to Non-Patients	0	18
19	Laboratory	7,534	19
20	Radiology and X-Ray	403	20
21	Other Medical Services	(309)	21
22	Laundry	0	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 108,634	23
	D. Non-Operating Revenue		
24	Contributions	(210)	24
25	Interest and Other Investment Income***	0	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ (210)	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)	0	27
28	AL/IL	0	28
28a	Misc Revenue	0	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 0	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,150,409	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,424,684	31
32	Health Care	3,481,947	32
33	General Administration	1,575,817	33
	B. Capital Expense		
34	Ownership	1,173,081	34
	C. Ancillary Expense		
35	Special Cost Centers	132,553	35
36	Provider Participation Fee	282,927	36
	D. Other Expenses (specify):		
37	0	0	37
38	0	0	38
39	0	0	39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,071,009	40
41	**Income before Income Taxes (line 30 minus line 40)****	(920,600)	41
42	**Income Taxes**	0	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (920,600)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 3,549,599	44
45	Private Pay - Net Inpatient Revenue	907,731	45
46	Medicare - Net Inpatient Revenue	1,436,819	46
47	Other-(specify) ALL OTHER SNF/SCF IP REVENUE	1,004,398	47
48	Other-(specify) C/A ANCILLARY ACCOUNTS	(1,375,640)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,522,908	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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.**

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr # 0047126 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	1,571	1,683	$ 50,849	$ 30.21	1
2	Assistant Director of Nursing	2,471	2,656	83,129	31.30	2
3	Registered Nurses	5,068	5,594	173,041	30.93	3
4	Licensed Practical Nurses	34,746	36,496	917,921	25.15	4
5	CNAs & Orderlies	85,329	89,130	1,255,867	14.09	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	0	0	0		7
8	Rehab/Therapy Aides	0	0	0		8
9	Activity Director	0	0	0		9
10	Activity Assistants	3,988	4,260	44,967	10.56	10
11	Social Service Workers	1,690	1,818	31,078	17.09	11
12	Dietician	0	0	0		12
13	Food Service Supervisor	0	0	0		13
14	Head Cook	21,540	22,622	215,660	9.53	14
15	Cook Helpers/Assistants	0	0	0		15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	7,972	8,322	133,041	15.99	17
18	Housekeepers	19,002	20,381	195,476	9.59	18
19	Laundry	3,514	3,883	42,637	10.98	19
20	Administrator	1,948	2,080	98,488	47.35	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	0	0	0		22
23	Office Manager	7,250	7,785	138,043	17.73	23
24	Clerical	0	0	0		24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	0	0	0		27
28	Qualified MR Prof. (QMRP)	0	0	0		28
29	Resident Services Coordinator	0	0	0		29
30	Habilitation Aides (DD Homes)	0	0	0		30
31	Medical Records	402	460	15,798	34.34	31
32	Other Health Care(specify)	3,595	3,823	33,234	8.69	32
33	Other(specify)	1,936	2,080	48,052	23.10	33
34	TOTAL (lines 1 - 33)	202,022	213,073	$ 3,477,281 *	$ 16.32	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	0	$ 12,982	01 - 03	35
36	Medical Director	0	25,289	09 - 03	36
37	Medical Records Consultant	0	0		37
38	Nurse Consultant	0	0		38
39	Pharmacist Consultant	0	0		39
40	Physical Therapy Consultant	0	359,242	10A-3	40
41	Occupational Therapy Consultant	0	223,222	10A-3	41
42	Respiratory Therapy Consultant	0	0		42
43	Speech Therapy Consultant	0	24,388	10A-3	43
44	Activity Consultant	0	0		44
45	Social Service Consultant	0	13,005	12 - 3	45
46	Other(specify)	0	0		46
47		0	0		47
48		0	0		48
49	TOTAL (lines 35 - 48)		$ 658,128		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				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr # 0047126 Report Period Beginning: 1/1/18 Ending: 12/31/18

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Rachel May	Administrator	0	$ 98,488
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 98,488

B. Administrative - Other

Description	Amount
SAK Management Svcs Mgmt Fees	$ 355,823
SAK Management Services - Administrative Consultant	(40,819)
TOTAL (agree to Schedule V, line 17, col. 3)	$ 315,004
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
Stout Risius Ross LLC	Administrative Consultant	1,582
Personnel Planners Inc	Unemployment Consultant	3,375
Polsinelli Shughart PC	Legal Fees	33,868
Plante & Moran PLLC	Accounting Services	46,133
Point Click Care	Data Processing	30,734
Compu-Solutions Inc	Data Processing	19,200
Proliant	Data Processing	4,357
Future Wave Tech Inc	Data Processing	18,669
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 157,917

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 69,059
Unemployment Compensation Insurance	31,297
FICA Taxes	253,054
Employee Health Insurance	(537)
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Misc Benefits	9,667
Less Marketing Benefits	(5,010)
SAK Management	45,570
TOTAL (agree to Schedule V, line 22, col.8)	$ 403,101

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	3,693
Patient Background Checks	
Dues & Subscriptions	13,080
Licenses & Permits	5,241
Recruiting Fee	37,527
SAK Management	11,287
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 70,828

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
SAK Management	24,134
Seminar Expense	10,912
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 35,046

**See instructions.

Facility Name & ID Number St Anthonys Nsg & Rehab Ctr # 0047126 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. **ICLTC - 13,080**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

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

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **46,745** Line **10-02**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **282,927**
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. $ **0** Has any meal income been offset against related costs? **N/A** 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? **Ln 14**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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

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