FOR BHF USE

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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 Rehab Ctr

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

County: St Clair

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

HFS ID Number:

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

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Amanda Springborn **Telephone Number:** (314) 925-3838
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/20 to 12/31/20 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) Sheldon Wolfe
(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 Rehab Ctr # 0039644 Report Period Beginning: 01/01/20 Ending: 12/31/20

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	150	Skilled (SNF)	150	54,900	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	150	TOTALS	150	54,900	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	50		3,669	3,719	8
9	SNF/PED					9
10	ICF	28,382	3,121	2,733	34,236	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,432	3,121	6,402	37,955	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.13%

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 150 and days of care provided 3,632

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2020 Fiscal Year: 12/31/2020

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

Facility Name & ID Number Caseyville Nursing Rehab Ctr # 0039644 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	371,376	42,086	7,356	420,818		420,818		420,818			1
2	Food Purchase		298,339		298,339		298,339	(26,551)	271,788			2
3	Housekeeping	175,587	86,213	-	261,800		261,800	14	261,814			3
4	Laundry	90,320	14,004	-	104,324		104,324		104,324			4
5	Heat and Other Utilities			162,158	162,158		162,158	1,150	163,308			5
6	Maintenance	72,194	55,507	16,098	143,799		143,799	2,067	145,866			6
7	Other (specify):*	-	-	-								7
8	TOTAL General Services	709,477	496,149	185,612	1,391,238		1,391,238	(23,320)	1,367,918			8
	B. Health Care and Programs											
9	Medical Director	-	-	13,228	13,228		13,228		13,228			9
10	Nursing and Medical Records	2,436,237	198,286	34,372	2,668,895		2,668,895	33,402	2,702,297			10
10a	Therapy	-	-	-								10a
11	Activities	82,143	8,998	-	91,141		91,141		91,141			11
12	Social Services	33,825	-	-	33,825		33,825		33,825			12
13	CNA Training	-	-	-								13
14	Program Transportation	-	-	-								14
15	Other (specify):*	-	-	-								15
16	TOTAL Health Care and Programs	2,552,205	207,284	47,600	2,807,089		2,807,089	33,402	2,840,491			16
	C. General Administration											
17	Administrative	94,168	-	411,720	505,888		505,888	(389,720)	116,168			17
18	Directors Fees			-								18
19	Professional Services			57,501	57,501		57,501	4,107	61,608			19
20	Dues, Fees, Subscriptions & Promotions			36,602	36,602		36,602	(7,514)	29,088			20
21	Clerical & General Office Expenses	536,598	-	73,651	610,249		610,249	57,306	667,555			21
22	Employee Benefits & Payroll Taxes			487,244	487,244		487,244	26,080	513,324			22
23	Inservice Training & Education			-								23
24	Travel and Seminar			1,222	1,222		1,222	399	1,621			24
25	Other Admin. Staff Transportation		-	14,522	14,522		14,522	425	14,947			25
26	Insurance-Prop.Liab.Malpractice			76,587	76,587		76,587	21,944	98,531			26
27	Other (specify):* Mgmt Alloc of Benefits			-				19,873	19,873			27
28	TOTAL General Administration	630,766		1,159,049	1,789,815		1,789,815	(267,100)	1,522,715			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,892,448	703,433	1,392,261	5,988,142		5,988,142	(257,018)	5,731,124			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 Rehab Ctr #0039644 Report Period Beginning: 01/01/20 Ending: 12/31/20

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			15,593	15,593		15,593	256,329	271,922			30
31	Amortization of Pre-Op. & Org.			-								31
32	Interest			28,720	28,720		28,720	168,822	197,542			32
33	Real Estate Taxes			-				34,001	34,001			33
34	Rent-Facility & Grounds			564,000	564,000		564,000	(564,000)				34
35	Rent-Equipment & Vehicles			10,912	10,912		10,912	1,036	11,948			35
36	Other (specify):* Mortgage Insurance			-				23,836	23,836			36
37	TOTAL Ownership			619,225	619,225		619,225	(79,976)	539,249			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation	-	-	-								38
39	Ancillary Service Centers	-	142,757	850,689	993,446		993,446		993,446			39
40	Barber and Beauty Shops	-	-	-								40
41	Coffee and Gift Shops	-	-	-								41
42	Provider Participation Fee			306,612	306,612		306,612		306,612			42
43	Other (specify):* Non-Allowable Cos	-	-	38,710	38,710		38,710	(38,710)				43
44	TOTAL Special Cost Centers		142,757	1,196,011	1,338,768		1,338,768	(38,710)	1,300,058			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,892,448	846,190	3,207,497	7,946,135		7,946,135	(375,704)	7,570,431			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 Rehab Ctr # 0039644 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	67,112	30		9
10	Interest and Other Investment Income	(7,060)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(468)	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	(69)	43		18
19	Entertainment				19
20	Contributions	(400)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(10,502)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	407	43		24
25	Fund Raising, Advertising and Promotional	(16,410)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See PG5A	(34,915)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (2,305)		$	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)	(373,399)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (373,399)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (375,704)		37

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

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

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

Caseyville Nursing Rehab Ctr

ID# 0039644

Report Period Beginning: 01/01/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Lab Expense Med A	$ (6,877)	43	1
2	X Ray Expense Med A	(11,843)	43	2
3	Managed Care Cost	(3,050)	43	3
4	Offset Miscellaneous Income	(1,670)	21	4
5	Lobbying Expense	(11,475)	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**	(34,915)		49

Facility Name & ID Number Caseyville Nursing Rehab Ctr # 0039644 Report Period Beginning: 01/01/20 Ending: 12/31/20

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%	$ 10,215	$ 10,215	1
2	V	21	Miscellaneous Expense		Caseyville Property LLC	100%	75	75	2
3	V	26	Insurance-Prop.Liab.Malpractice		Caseyville Property LLC	100%	20,254	20,254	3
4	V	30	Depreciation		Caseyville Property LLC	100%	184,917	184,917	4
5	V	32	Interest	41	Caseyville Property LLC	100%	175,923	175,882	5
6	V	33	Real Estate Taxes		Caseyville Property LLC	100%	30,407	30,407	6
7	V	34	Rent	564,000	Caseyville Property LLC	100%		(564,000)	7
8	V	36	Mortgage Insurance		Caseyville Property LLC	100%	23,836	23,836	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 564,041			$ 445,627	$ * (118,414)	14

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

Facility Name & ID Number Caseyville Nursing Rehab Ctr # 0039644 Report Period Beginning: 01/01/20 Ending: 12/31/20

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%	$ 176	$ 176	15
16	V	3	Housekeeping		SW Financial Services Company	100%	14	14	16
17	V	5	Utilities		SW Financial Services Company	100%	1,150	1,150	17
18	V	6	Maintenance		SW Financial Services Company	100%	2,067	2,067	18
19	V	17	Administrative	411,720	SW Financial Services Company	100%	22,000	(389,720)	19
20	V	19	Professional Services		SW Financial Services Company	100%	4,394	4,394	20
21	V	20	Dues, Fees, Subscriptions & Promotions		SW Financial Services Company	100%	2,761	2,761	21
22	V	21	Clerical & General Office Expenses		SW Financial Services Company	100%	93,503	93,503	22
23	V	24	Travel & Seminar		SW Financial Services Company	100%	399	399	23
24	V	25	Other Admin. Staff Transportation		SW Financial Services Company	100%	425	425	24
25	V	26	Insurance-Prop, Liab & Malpractice		SW Financial Services Company	100%	1,690	1,690	25
26	V	27	Other		SW Financial Services Company	100%	19,873	19,873	26
27	V	30	Depreciation		SW Financial Services Company	100%	4,300	4,300	27
28	V	33	Real Estate Taxes		SW Financial Services Company	100%	3,594	3,594	28
29	V	35	Rent - Equipment & Vehicles		SW Financial Services Company	100%	1,036	1,036	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			$ 411,720			$ 157,382	$ * (254,338)	39

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

Facility Name & ID Number Caseyville Nursing Rehab Ctr # 0039644 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	$ 7,114	S & E Medical Supply Co.	95.00%	$ 6,467	$ (647)	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			$ 7,114			$ 6,467	$ * (647)	39

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

Facility Name & ID Number Caseyville Nursing Rehab Ctr # 0039644 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Abraham J Stern	4.67	Cahokia Nursing and Rehab	Cahokia	Prairie Crossing Suppo	Shabbona	Supportive Living	1
2	Albert Milstein	26.33	Caseyville Nursing and Rehab	Caseyville	Living Center, LLC		Facility	2
3	Sheldon Wolfe	23.67			SW Financial	Skokie	Bookkeeping/	3
4	Ronnie Klein as Trustee	4.99			Services Co.		Management Compa	4
5	Maurice Aaron	4.67	Franklin Grove Living & Rehabilitation, LLC	Franklin Grove	S&E Medical Supply C	Skokie	Medical Supplies	5
6	Michael Klein Revocable Trust	1.99	Oregon Living & Rehabilitation, LLC	Oregon				6
7	Wanda Bowling	0.67	Prairie Crossing Living & Rehab Center	Shabbona	Groves Community	Independence, MO	Hospice	7
8	Miriam Y Klein as Trustee	6.67			Hospice			8
9	Michael A Klein as Trustee	6.67			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 Estate	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 LI	South Elgin	Real Estate	28
29								29
30								30

Facility Name & ID Number Caseyville Nursing Rehab Ctr # 0039644 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 Prope	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 Rehab Ctr # 0039644 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
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 Rehab Ctr # 0039644 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	678,198	12	$ 2,175	$	54,900	$ 176	1
2	3	Housekeeping	Bed Days Available	678,198	12	179		54,900	14	2
3	5	Utilities	Bed Days Available	678,198	12	14,206		54,900	1,150	3
4	6	Maintenance	Bed Days Available	678,198	12	25,536		54,900	2,067	4
5	19	Professional Services-Legal	Bed Days Available	678,198	12	29,559		54,900	2,393	5
6	19	Professional Services-Other	Bed Days Available	678,198	12	24,713		54,900	2,001	6
7	20	Dues, Fees, Subscriptions & Promo	Bed Days Available	678,198	12	34,103		54,900	2,761	7
8	21	Clerical & General Office Expense	Bed Days Available	678,198	12	962,284	962,284	54,900	77,897	8
9	21	Clerical & General Office Expense	Bed Days Available	678,198	12	192,782		54,900	15,606	9
10	24	Travel & Seminar	Bed Days Available	678,198	12	4,935		54,900	399	10
11	25	Other Admin. Staff Transportion	Bed Days Available	678,198	12	5,250		54,900	425	11
12	26	Insurance-Prop, Liab & Malpracti	Bed Days Available	678,198	12	20,882		54,900	1,690	12
13	27	Other - Mgmt Allocation of Benefi	Bed Days Available	678,198	12	245,503		54,900	19,873	13
14	33	Real Estate Taxes	Bed Days Available	678,198	12	44,398		54,900	3,594	14
15	35	Rent - Equipment & Vehicles	Bed Days Available	678,198	12	12,804		54,900	1,036	15
16										16
17	17	Administrative - Salary	Average Hours Worked	45	12	13,000	13,000	5	1,444	17
18	17	Administrative - Salary	Average Hours Worked	45	12	185,000	185,000	5	20,556	18
19										19
20	30	Depreciation	Direct Cost	53,119					4,300	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,817,309	$ 1,160,284		$ 157,382	25

Facility Name & ID Number Caseyville Nursing Rehab Ctr # 0039644 Report Period Beginning: 01/01/20 Ending: 12/31/20

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			$	$		$ 6,467	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					$	$		$ 6,467	25

Facility Name & ID Number Caseyville Nursing Rehab Ctr # 0039644 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	$ 4,670,497	12/1/2036	0.0635	$ 175,923	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Member Loan	X		Working Capital	Varies	5/15/2016	1,000,000	-	5/15/2020	0.05	28,720	6
7	Wisconsin Physician Services		X	MCR Advance Payments	16,616	4/30/2020	398,781	398,781	4/30/2022			7
8												8
9	TOTAL Facility Related				$55,512		$ 8,212,781	$ 5,069,278			$ 204,643	9
	B. Non-Facility Related*											
10												10
11												11
12								Interest Income			(7,101)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (7,101)	14
15	TOTALS (line 9+line14)						$ 8,212,781	$ 5,069,278			$ 197,542	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 23,836 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 Rehab Ctr # 0039644 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 71,900	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.)	2019	$ 50,407	2
3. Under or (over) accrual (line 2 minus line 1).		$ (21,493)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 51,900	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	Alloc. Fr. Mgmt. Co.	$ 3,594	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.		$ 34,001	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2016	65,185	8
	2017	68,448	9
	2018	69,013	10
	2019	69,783	11
	2020	50,407	12

2020 Tax Accrual = 50,407*1.03 = 51,919. Use 51,900

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	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.**

2019 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 2019 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 2019.

	(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	$ 50,406.90	$ 50,406.90
2.	10-28-412-049-0000	SW Financial Services Co. Allocation	$ 44,397.67	$ 3,594.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 94,804.57	$ 54,000.90

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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 Rehab Ctr # 0039644 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 Rehab Ctr # 0039644 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	$ 135,005	$ 135,005	$ 2,720,930	4
5											5
6											6
7											7
8	Allocated from Management Co.		1995		35,038			1,001	1,001	25,679	8
	Improvement Type**										
9	Various			1994	22,304	58	20		(58)	22,304	9
10	Various			1995	52,604	107	20		(107)	52,604	10
11	Various			1996	2,492		20			2,492	11
12	Various			1997	11,349		20			11,349	12
13	Various			1998	14,511	227	20		(227)	14,511	13
14	Various			1999	83,394		20			83,394	14
15	Parking Lot			2000	2,830		20	71	71	2,813	15
16	Sprinkler System			2000	3,385	87	20	59	(28)	3,385	16
17	Sprinkler System			2000	5,820	149	20	73	(76)	5,820	17
18	A/C Repairs			2000	1,018		10			1,018	18
19	Ac Repairs			2000	1,102		20	24	24	1,102	19
20	Draperies			2000	1,052		20	36	36	1,052	20
21	Carpeting			2000	1,578		20	24	24	1,578	21
22	Air Handler			2000	1,786		20	46	46	1,786	22
23	Air Conditioner			2000	1,963		7	639	639	1,963	23
24	Air Handler			2000	1,241		20	32	32	1,241	24
25	Air Conditioner			2000	1,029		20	22	22	1,029	25
26	Compressor			2000	1,800		20			1,800	26
27	Booster Heater			2000	1,675		20			1,675	27
28	Air Conditioner			2000	5,821		20	195	195	5,821	28
29	Air Conditioner			2000	17,320		20	361	361	17,320	29
30	Air Conditioner			2001	3,630		20	182	182	3,575	30
31	Air Conditioner			2001	3,630		20	182	182	3,575	31
32	Air Conditioner			2001	3,111		20	156	156	3,064	32
33	Blinds			2001	1,212		20	61	61	1,206	33
34	Sprinkler Repair			2001	1,609		20	80	80	1,590	34
35	Sprinkler Heads			2001	2,145		20	107	107	2,106	35
36	Pipes Repair			2001	1,903		20	95		1,814	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 Rehab Ctr # 0039644 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	8,999	43
44	Dry Value System	2003	5,623	144	20	281	137	4,942	44
45	Landscaping	2003	8,800		20	440	440	7,627	45
46	Nursing Stations	2003	35,000		20	1,750	1,750	29,896	46
47	Repair Fire Protection Equipment	2003	1,694		20	85	85	1,528	47
48	P.A. Amplifier	2003	713		20	36	36	645	48
49	Security Systems	2004	23,268	901	20	1,163	262	19,193	49
50	16 Transmitters	2004	1,517		20	76	76	1,253	50
51	Nurses Stations	2004	35,000		20	1,750	1,750	28,875	51
52	Wardrobe units w/ Installation	2004	46,731	2,972	20	2,337	(635)	38,557	52
53	Cabinets and Countertops	2005	85,938	3,125	20	4,297	1,172	66,603	53
54	Air Conditioners	2005	20,666		7			20,666	54
55	Freezer Door	2005	2,100		20	105	105	1,628	55
56	Wallpaper	2005	16,140		5			16,140	56
57	Sprinkler System	2005	5,545	202	20	277	75	4,296	57
58	Painting and Wallcovering	2005	38,520		5			38,520	58
59	Air Condensors	2005	6,270	228	20	314	86	4,864	59
60	Vinyl Flooring	2005	5,009	182	5		(182)	5,009	60
61	Paving and Sealing Sidewalks	2005	7,000	413	15	231	(182)	7,000	61
62	Metal Doors	2005	1,926	70	20	96	26	1,490	62
63	Kitchen Floor	2006	10,300	375	20	515	140	7,468	63
64	Sprinkler System	2006	9,529	346	20	476	130	6,905	64
65	Door Monitors & Paging System	2006	811		20	41	41	592	65
66	Exterior Security Lighting	2006	4,180	152	20	209	57	3,031	66
67	6 A/C Units	2006	2,576		20	129	129	1,869	67
68	6 A/C Units	2006	2,576		20	129	129	1,869	68
69	Fuel Pump & Injectors	2006	4,719	172	20	236	64	3,422	69
70	TOTAL (lines 4 thru 69)		$ 5,972,040	$ 10,357		$ 153,920	$ 143,468	$ 3,358,842	70

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

Facility Name & ID Number Caseyville Nursing Rehab Ctr # 0039644 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 5,972,040	$ 10,357		$ 153,920	$ 143,563	$ 3,358,842	1
2	3 Ton & 1 1/2 Ton A/C Units	2006	3,702	135	20	185	50	2,683	2
3	Duct Heater	2006	1,349	49	20	67	18	974	3
4	Shower Room Remodel (E Hall)	2006	9,210	335	20	461	126	6,682	4
5	Demolish and Rebuild Shower Room	2007	57,900	2,018	20	2,895	877	39,083	5
6	4 Hot Water Heaters	2007	13,462	367	20	673	306	9,086	6
7	Vinyl Siding, Gutters, Downspouts, Shutters, Soffit, Facia	2007	39,450	1,434	20	1,973	539	26,634	7
8	Repair Sprinkler System	2007	3,957		20	198	198	2,673	8
9	Oak flooring	2008	15,571	566	20	778	212	9,735	9
10	Fire alarm system	2008	8,858	322	20	443	121	5,537	10
11	Street and parking lot paving	2008	43,360	1,280	20	2,168	888	27,100	11
12	Replace 3 inch main	2008	4,716	171	20	236	65	2,949	12
13	Replace hot water pipes	2008	39,504	1,437	20	1,975	538	24,689	13
14	Replace pipe and fitting	2009	4,232	154	20	211	57	2,436	14
15	Air Handling Equipment	2010	22,154	806	20	1,108	302	11,634	15
16	Plumbing Value	2011	4,600	167	20	230	63	2,185	16
17	Hot water system	2011	6,900	251	20	345	94	3,278	17
18	Sprinkler Work	2011	20,035	729	20	1,002	273	9,934	18
19	Direct TV system Installation	2011	7,000		20	350	350	3,325	19
20	Handicap shower stall	2011	2,955	107	20	148	41	1,404	20
21									21
22	71 Gallon Hot Water Heater: Nurse Station Mechanical Room	2012	3,388	123	20	169	46	1,441	22
23	100 Gallon Hot Water Heater: Dietary/Maint. Electrical Room	2012	4,917	179	20	246	67	2,090	23
24	Lighting - Electrical Work: All Resident Rooms	2012	9,975	363	20	499	136	4,239	24
25	Fire Alarm: Whole Facility	2012	6,434	234	20	322	88	2,707	25
26									26
27	81 Gallon Hot Water Heater	2013	4,624		7	55	55	4,624	27
28	New Door	2013	3,094		7	405	405	3,094	28
29	100 Gallon Hot Water Heater:	2013	6,236		7	890	890	6,236	29
30									30
31									31
32	Belt Drive Rooftop Ventilator	2014	3,197		10	320	320	2,051	32
33	Countertop and Back Splash	2014	5,593		10	559	559	3,869	33
34	TOTAL (lines 1 thru 33)		$ 6,328,413	$ 21,584		$ 172,831	$ 151,247	$ 3,581,213	34

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

Facility Name & ID Number Caseyville Nursing Rehab Ctr # 0039644 Report Period Beginning: 01/01/20 Ending: 12/31/20

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		$ 6,328,413	$ 21,584		$ 172,831	$ 151,247	$ 3,581,213	1
2	7 Electric Door Holder/Closers	2015	10,102		20	505	505	2,778	2
3	Walk Path Improvements	2015	15,875		20	794	794	4,365	3
4	Hot Water Heater	2015	3,569		5	356	356	3,569	4
5									5
6	Siding for Cupola	2016	3,677	134	20	184	50	827	6
7	Clinic Service Sink Replacement	2016	3,909	142	20	195	53	880	7
8	2 Hot Water Heaters - Mechanical Room	2016	12,531		5	2,506	2,506	11,278	8
9	Hot Water Heater - Nurses Station	2016	7,050		5	1,410	1,410	6,345	9
10	Time Clock - 400 Hall in back of building by break room	2016	9,277		5	1,855	1,855	8,349	10
11	4 Custom Duct Heaters 200, 300, 400 & 600 halls	2016	3,650		5	730	730	3,285	11
12									12
13	Walk-In Cooler - Kitchen	2017	18,495	673	20	925	252	3,083	13
14	Install Fire Alarm	2017	3,430	125	20	172	47	601	14
15	98 gallon Water heater	2017	13,801		5	2,760	2,760	10,350	15
16	Install Sprinkler System - Entire Building	2017	250,800		20	12,540	12,540	43,890	16
17	Plan Submission Fee for Sprinklers - Entire Building	2017	3,010	109	5	602	493	2,358	17
18									18
19	Furnish & Install Building Front Doors - Main Exterior Entrance	2018	4,822	175	20	241	66	603	19
20									20
21	RE Install new water heater and associate piping	2019	4,925		20	246	246	369	21
22	RE Replace Lennox Condenser model ELS090S4S- Kitchen AC uni	2019	4,783		20	239	239	359	22
23	RE Fire alarm installation charges	2019	4,966		20	248	248	372	23
24	RE Security system and installation	2019	3,205		20	160	160	240	24
25	RE Replacement of fire alarm	2019	10,000		20	500	500	750	25
26									26
27	Install 2 water heaters	2020	26,876		20	672	672	672	27
28	Install accutech system - throughout facility	2020	9,238		20	231	231	231	28
29	Install Lightning Protection System - Entire facility	2020	17,625		20	441	441	441	29
30									30
31	Tie to Financials			(7,349)			7,349		31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,774,029	$ 15,593		$ 201,344	$ 185,751	$ 3,687,208	34

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

Facility Name & ID Number Caseyville Nursing Rehab Ctr # 0039644 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 12C, Carried Forward		$ 6,774,029	$ 15,593		$ 201,344	$ 185,751	$ 3,687,208	1
2									2
3	Allocated from SW Financial Services Co. - Leasehold Improvemen	1995	3,921					3,921	3
4	Allocated from SW Financial Services Co. - Leasehold Improvemen	1996	653					653	4
5	Allocated from SW Financial Services Co. - Leasehold Improvemen	1997	757					757	5
6	Allocated from SW Financial Services Co. - Leasehold Improvemen	1998	647					647	6
7	Allocated from SW Financial Services Co. - Leasehold Improvemen	1999	1,797					1,797	7
8	Allocated from SW Financial Services Co. - Leasehold Improvemen	2005	3,718			186	186	2,881	8
9	Allocated from SW Financial Services Co. - Leasehold Improvemen	2007	2,105			105	105	1,421	9
10	Allocated from SW Financial Services Co. - Leasehold Improvemen	2009	4,394			220	220	2,527	10
11	Allocated from SW Financial Services Co. - Leasehold Improvemen	2013	2,346			117	117	880	11
12	Allocated from SW Financial Services Co. - Leasehold Improvemen	2014	2,366			118	118	769	12
13	Allocated from SW Financial Services Co. - Leasehold Improvemen	2015	484			32	32	178	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	TOTAL (lines 1 thru 33)		$ 6,797,217	$ 15,593		$ 202,122	$ 186,529	$ 3,703,639	34

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

Facility Name & ID Number Caseyville Nursing Rehab Ctr # 0039644 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	$ 1,482,615	$	$ 64,091	$ 64,091	5-10	$ 1,277,075	71
72	Current Year Purchases	31,886		3,189	3,189	5	3,189	72
73	Fully Depreciated Assets	43,707				5-10	43,707	73
74	Allocated from Management Co.	15,581		804	804	5-10	12,146	74
75	TOTALS	$ 1,573,789	$	$ 68,084	$ 68,084		$ 1,336,117	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 C	2017 Land Rover Evoque	2017	8,582	-	1,716	1,716	5	6,007	79
80	TOTALS			$ 48,589	$	$ 1,716	$ 1,716		$ 46,014	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)	$ 8,769,595	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 15,593	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 271,922	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 256,329	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,085,770	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 Rehab Ctr # 0039644 Report Period Beginning: 01/01/20 Ending: 12/31/20

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.	/2021	$
13.	/2022	$
14.	/2023	$

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

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

16. Rental Amount for movable equipment: $ 10,912 Description: Medical Equipment
(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.		$	$ 1,036	17
18					18
19					19
20					20
21	TOTAL		$	$ 1,036	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 Rehab Ctr # 0039644 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L39, C3	hrs	$	5,808	$ 418,203	$	5,808	$ 418,203	1
2	Licensed Speech and Language Development Therapist	L39, C3	hrs		1,303	93,788		1,303	93,788	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L39, C3	hrs		4,704	338,698		4,704	338,698	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				132,509		132,509	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Oxygen	L39, C2					10,248		10,248	12
13	Other (specify):									13
14	TOTAL			$	11,815	$ 850,689	$ 142,757	11,815	$ 993,446	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 Rehab Ctr # 0039644 Report Period Beginning: 01/01/20 Ending: 12/31/20

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/20 (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	$ 537,479	$ 749,492	1
2	Cash-Patient Deposits	-	-	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 91,340)	2,485,060	2,485,060	3
4	Supply Inventory (priced at)	-	-	4
5	Short-Term Investments	-	-	5
6	Prepaid Insurance	10,192	22,653	6
7	Other Prepaid Expenses	-	-	7
8	Accounts Receivable (owners or related parties)	-	-	8
9	Other(specify): See Schedule 17A	2,230,614	2,496,866	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,263,345	$ 5,754,071	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	-	5,300,217	14
15	Leasehold Improvements, at Historical Cost	788,713	1,497,000	15
16	Equipment, at Historical Cost	275,257	1,622,378	16
17	Accumulated Depreciation (book methods)	(675,357)	(5,085,770)	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	-	50,311	22
23	Other(specify):	-	-	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 388,613	$ 3,734,136	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,651,958	$ 9,488,207	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 149,737	$ 157,517	26
27	Officer's Accounts Payable	-	-	27
28	Accounts Payable-Patient Deposits	112,428	112,428	28
29	Short-Term Notes Payable	-	-	29
30	Accrued Salaries Payable	104,258	104,258	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,379	11,379	31
32	Accrued Real Estate Taxes(Sch.IX-B)	-	51,900	32
33	Accrued Interest Payable	-	14,362	33
34	Deferred Compensation	-	-	34
35	Federal and State Income Taxes	-	-	35
	Other Current Liabilities(specify):			
36	See Schedule 17A	768,919	844,478	36
37		-	-	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,146,721	$ 1,296,322	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	-	398,781	39
40	Mortgage Payable	398,781	4,670,497	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)**	$ 398,781	$ 5,069,278	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,545,502	$ 6,365,600	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,106,456	$ 3,122,607	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,651,958	$ 9,488,207	48

*(See instructions.)

Facility Name: **Caseyville Nursing Rehab Ctr**
IDPH License ID Number: **0039644**
Fiscal Year End: **12/31/20**

Schedule 17A

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

Description	Operating	After Consolidation
Re Escrow - Insurance	-	28,402
Re Escrow-Mip	-	38,717
Re Replacement Reserve	-	144,565
Re Escrow- Real Estate Tax	-	54,568
Due From State - Interest	210,046	210,046
Employee Payroll Advance	808	808
Short Term Loan Exchange	1,944,202	1,944,202
Due/From Caseyville Prop. Llc	75,558	75,558
Total - Line 9	**2,230,614**	**2,496,866**
	-	-

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

Description	Operating	After Consolidation
Due From State	105,922	105,922
Due T/F Caseyville Nursing	-	(120,000)
Due To (From) G.P	-	195,559
Reimbursement Due	4,328	4,328
Due To State	292,000	292,000
Acc. Retirement (From P/R)	856	856
Accrued Expenses	365,813	365,813
Total - Line 36	**768,919**	**844,478**
	-	-

Facility Name & ID Number Caseyville Nursing Rehab Ctr # 0039644 Report Period Beginning: 01/01/20 Ending: 12/31/20

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,786,059	1	
2	Restatements (describe):		2	
3	**Record effects of 2019 section 163(j) election**	9,395	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,795,454	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,311,000	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe) **Rounding**	2	15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,311,002	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)**	$ 4,106,456	24	*

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

Facility Name & ID Number Caseyville Nursing Rehab Ctr # 0039644 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,432,043	1
2	Discounts and Allowances for all Levels	(-)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,432,043	3
	B. Ancillary Revenue		
4	Day Care	-	4
5	Other Care for Outpatients	-	5
6	Therapy	672,788	6
7	Oxygen	11,420	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 684,208	8
	C. Other Operating Revenue		
9	Payments for Education	-	9
10	Other Government Grants	1,130,433	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	360	19
20	Radiology and X-Ray	-	20
21	Other Medical Services	-	21
22	Laundry	-	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,130,793	23
	D. Non-Operating Revenue		
24	Contributions	-	24
25	Interest and Other Investment Income***	7,060	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 7,060	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	1,670	28
28a	Medicaid Income Adjustment	1,361	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,031	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,257,135	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,391,238	31
32	Health Care	2,807,089	32
33	General Administration	1,789,815	33
	B. Capital Expense		
34	Ownership	619,225	34
	C. Ancillary Expense		
35	Special Cost Centers	1,032,156	35
36	Provider Participation Fee	306,612	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,946,135	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,311,000	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,311,000	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,705,194	44
45	Private Pay - Net Inpatient Revenue	585,201	45
46	Medicare - Net Inpatient Revenue	1,969,318	46
47	Other-(specify) Hospice	172,330	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,432,043	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 Rehab Ctr # 0039644 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	1,896	2,144	$ 103,179	$ 48.12	1
2	Assistant Director of Nursing	1,623	1,807	72,371	40.06	2
3	Registered Nurses	1,868	2,097	78,584	37.47	3
4	Licensed Practical Nurses	25,991	28,468	968,327	34.01	4
5	CNAs & Orderlies	67,262	74,213	1,213,776	16.36	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,101	4,684	82,143	17.54	10
11	Social Service Workers	1,389	1,557	33,825	21.72	11
12	Dietician					12
13	Food Service Supervisor	2,000	2,272	69,315	30.51	13
14	Head Cook	7,929	8,774	135,438	15.44	14
15	Cook Helpers/Assistants	14,403	15,458	166,623	10.78	15
16	Dishwashers					16
17	Maintenance Workers	2,500	2,911	72,194	24.80	17
18	Housekeepers	14,303	15,308	175,587	11.47	18
19	Laundry	7,397	7,985	90,320	11.31	19
20	Administrator	2,075	2,080	94,168	45.27	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	14,478	15,615	433,345	27.75	23
24	Clerical	5,301	5,709	103,253	18.09	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Ca					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	174,513	191,079	$ 3,892,448 *	$ 20.37	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	$ 7,356	L1, C3	35
36	Medical Director	Monthly	13,228	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	7,326	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)		$ 27,910		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	375	19,687	L10, C3	51
52	Certified Nurse Assistants/Aides	342	7,359	L10, C3	52
53	TOTAL (lines 50 - 52)	717	$ 27,046		53

Facility Name & ID Number Caseyville Nursing Rehab Ctr # 0039644 Report Period Beginning: 01/01/20 Ending: 12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Robert Krebs	Administrator	0	$ 94,168
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 94,168

B. Administrative - Other

Description	Amount
SW Financial Services Co.-Home Office	$ 291,720
Management Fees	120,000
(Eliminated on Sch V, Column 7)	
TOTAL (agree to Schedule V, line 17, col. 3)	$ 411,720
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Abbey Road Tax Consultants	Legal	$ 6,963
American Express	Legal	55
Hepler Broom Llc	Legal	1,949
Mathis, Marifian & Richter Ltd	Legal	30,347
Polsinelli	Legal	5,462
Adjusting entries	Legal	(12,584)
RSM US LLP	Accounting	23,409
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)		$ 57,501

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 48,116
Unemployment Compensation Insurance	22,033
FICA Taxes	289,592
Employee Health Insurance	130,640
Employee Meals	26,080
Illinois Municipal Retirement Fund (IMRF)*	
Miscellaneous Employee Benefits	(750)
Employee Life Insurance	(2,387)
TOTAL (agree to Schedule V, line 22, col.8)	$ 513,324

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

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 39)	463
Patient Background Checks 237	2,370
Miscellaneous Inspections & Licenses	3,667
Miscellaneous Dues & Permits	6,362
Health Care Council of Illinois	22,950
Allocated from Management Co	2,761
Less: Lobbying Fees	(11,475)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 29,088

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,222
Allocated from Management Co.	399
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,621

**See instructions.

Facility Name: **Caseyville Nursing Rehab Ctr**
IDPH License ID Number: **0039644**
Fiscal Year End: **12/31/20**

Schedule 21C

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
From page 21 Professional fees		57,501
	Total (agree to Schedule V, line 19, column 3)	57,501
Allocated from Management Company	Legal Fees	2,393
Allocated from Management Company	Other	2,001
Allocated from Real Estate Entity		10,215
Less: Non-Allowable Legal Fees		(10,502)
	Total (agree to Schedule V, line 19, column 8)	61,608

Facility Name & ID Number Caseyville Nursing Rehab Ctr # 0039644 Report Period Beginning: 01/01/20 Ending: 12/31/20

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. **Health Care Council of Illinois-$22,950**

(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. $ **8,387** 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. $ **306,612**
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. $ **26,080** 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.