

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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

I. IDPH License ID Number: <u>0053637</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Rushville Nsg & Rehab Ctr</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/16</u> to <u>12/31/16</u> 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.																							
Address: <u>135 South Morgan St</u> <u>Rushville</u> <u>62681</u>																									
Number City Zip Code																									
County: <u>Schuyler</u>																									
Telephone Number: <u>(217) 322 - 3201</u> Fax # <u>(217) 322 - 2828</u>																									
HFS ID Number: _____		<table><tr><td rowspan="2">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Date) _____	Paid Preparer	(Type or Print Name) _____	(Title) _____	(Signed) _____	(Date) _____														
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	(Date) _____																								
Paid Preparer	(Type or Print Name) _____																								
	(Title) _____																								
	(Signed) _____																								
	(Date) _____																								
Date of Initial License for Current Owners: <u>07/31/15</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☒ Limited Liability Co.	_____		☐ Trust			☐ Other _____	
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	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:		<table><tr><td>MAIL TO: BUREAU OF HEALTH FINANCE</td></tr><tr><td>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</td></tr><tr><td>201 S. Grand Avenue East</td></tr><tr><td>Springfield, IL 62763-0001</td></tr><tr><td>Phone # (217) 782-1630</td></tr></table>		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																	
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201 S. Grand Avenue East																									
Springfield, IL 62763-0001																									
Phone # (217) 782-1630																									
Name: <u>Edward N. Slack, CPA</u>																									
Telephone Number: <u>(847) 628 - 8796</u>																									
Email Address: _____																									

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Rushville Nsg & Rehab Ctr

0053637 Report Period Beginning: 01/01/16 Ending: 12/31/16

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds <u>N/A</u>					
	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>49</u>	Skilled (SNF)	<u>49</u>	<u>17,934</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>50</u>	Intermediate (ICF)	<u>50</u>	<u>18,300</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>99</u>	TOTALS	<u>99</u>	<u>36,234</u>	7

B. Census-For the entire report period.						
	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>5,045</u>	<u>3,053</u>	<u>2,559</u>	<u>10,657</u>	8
9	SNF/PED					9
10	ICF	<u>5,148</u>	<u>3,116</u>	<u>205</u>	<u>8,469</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>10,193</u>	<u>6,169</u>	<u>2,764</u>	<u>19,126</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 52.78%

SEE ACCOUNTANTS' PREPARATION REPORT

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

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

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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 07/31/15

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 07/31/15 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 49 and days of care provided 2,358

Medicare Intermediary National Government Services, Inc.

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/16 Fiscal Year: 12/31/16
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Rushville Nsg & Rehab Ctr # 0053637 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	185,241	22,957	5,496	213,694		213,694	72	213,766			1
2	Food Purchase		135,627		135,627		135,627	155	135,782			2
3	Housekeeping	55,957	15,649		71,606		71,606	399	72,005			3
4	Laundry	39,035	11,103		50,138		50,138		50,138			4
5	Heat and Other Utilities			82,707	82,707		82,707	556	83,263			5
6	Maintenance	67,400	5,338	64,312	137,050		137,050	4,645	141,695			6
7	Other (specify):* See Supplemental							326	326			7
8	TOTAL General Services	347,633	190,674	152,515	690,822		690,822	6,153	696,975			8
	B. Health Care and Programs											
9	Medical Director			2,400	2,400		2,400		2,400			9
10	Nursing and Medical Records	971,688	39,664	1,999	1,013,351		1,013,351		1,013,351			10
10a	Therapy	8,938			8,938		8,938		8,938			10a
11	Activities	38,150	5,769	792	44,711		44,711		44,711			11
12	Social Services	9,073	40	1,749	10,862		10,862		10,862			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* See Supplemental											15
16	TOTAL Health Care and Programs	1,027,849	45,473	6,940	1,080,262		1,080,262		1,080,262			16
	C. General Administration											
17	Administrative	112,092			112,092		112,092	7,788	119,880			17
18	Directors Fees											18
19	Professional Services			177,395	177,395		177,395	(115,322)	62,073			19
20	Dues, Fees, Subscriptions & Promotions			35,481	35,481		35,481	(10,429)	25,052			20
21	Clerical & General Office Expenses	116,626	24,794	415,438	556,858		556,858	(352,384)	204,474			21
22	Employee Benefits & Payroll Taxes			247,116	247,116		247,116	(2,017)	245,099			22
23	Inservice Training & Education			3,024	3,024		3,024		3,024			23
24	Travel and Seminar			4,288	4,288		4,288	59	4,347			24
25	Other Admin. Staff Transportation			21,599	21,599		21,599	402	22,001			25
26	Insurance-Prop.Liab.Malpractice			70,810	70,810		70,810	697	71,507			26
27	Other (specify):* See Supplemental							9,146	9,146			27
28	TOTAL General Administration	228,718	24,794	975,151	1,228,663		1,228,663	(462,060)	766,603			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,604,200	260,941	1,134,606	2,999,747		2,999,747	(455,907)	2,543,840			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

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

Page 3 Supplemental Schedule

Description	Salaries	Supplies	Other	Total
Line 7 - Other General Services				
Alloc. - Extended Care Consulting, LLC				-
Gen. Services - Employee Benefits			326	326
				-
				-
				-
				-
				-
				-
Sub-Total	-	-	326	326
Line 15 - Other Health Care Services				
				-
				-
				-
				-
				-
				-
				-
Sub-Total	-	-	-	-
Line 27 - Other General Administration				
Alloc. - Extended Care Consulting, LLC				-
Gen. Admin. - Employee Benefits			9,146	9,146
				-
				-
				-
				-
				-
Sub-Total	-	-	9,146	9,146

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

Page 3 Supplemental Schedule - Other Staff Administration Travel Expense

Employee	Travel Purpose	Travel Destination	Travel Date	Expenses			Total
				Travel	Accomodations	Meals	
American Express	Business Matters	Various	Various	7,354			7,354
Amy Moon	Business Matters	Various	Various	202			202
Angela Carver	Business Matters	Various	Various	182			182
Care Management Facility	Business Matters	Various	Various	3,454			3,454
Keesha Stell	Business Matters	Various	Various	54			54
Laura Sepessy	Business Matters	Various	Various	456			456
Lea Jolley-Kaufman	Business Matters	Various	Various	869			869
Melinda Murk	Business Matters	Various	Various	1,966			1,966
Melissa Conover	Business Matters	Various	Various	227			227
Michelle Shaffer	Business Matters	Various	Various	144			144
Patricia Bedwell	Business Matters	Various	Various	6,278			6,278
Rick Peterman	Business Matters	Various	Various	380			380
Sharon Wright	Business Matters	Various	Various	34			34
							-
							-
Alloc. - Extended Care Consulting, LLC				402			402
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
Total				22,001	-	-	22,001

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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			6,111	6,111		6,111	178,549	184,660			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							72,030	72,030			32
33	Real Estate Taxes			40,444	40,444		40,444	125	40,569			33
34	Rent-Facility & Grounds			260,714	260,714		260,714	(260,714)				34
35	Rent-Equipment & Vehicles			11,656	11,656		11,656	380	12,036			35
36	Other (specify):* See Supplemental											36
37	TOTAL Ownership			318,925	318,925		318,925	(9,630)	309,295			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		94,662	331,164	425,826		425,826		425,826			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			158,574	158,574		158,574		158,574			42
43	Other (specify):* See Supplemental											43
44	TOTAL Special Cost Centers		94,662	489,738	584,400		584,400		584,400			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	1,604,200	355,603	1,943,269	3,903,072		3,903,072	(465,537)	3,437,535			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

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				9
10	Interest and Other Investment Income	(51)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(391,505)	21		24
25	Fund Raising, Advertising and Promotional	(10,807)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Supplemental Schedule	(17,113)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (419,476)		\$	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)	(46,061)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (46,061)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (465,537)		37

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Other Income	\$ (256)	21	1
2	Professional Fees - Architecture	(3,645)	19	2
3	Bank Charges	(3,105)	21	3
4				4
5				5
6	Rushville Healthcare Properties, LLC			6
7	Management Fees	(1,000)	19	7
8	Professional Fees	(6,250)	19	8
9	Licenses	(250)	21	9
10	Bank Charges	(150)	21	10
11	Amortization	(2,457)	31	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	(17,113)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rushville Nsg & Rehab Ctr# 0053637

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	72	0	0	0	0	0	0	0	0	72	1
2	Food Purchase	0	0	155	0	0	0	0	0	0	0	0	155	2
3	Housekeeping	0	0	399	0	0	0	0	0	0	0	0	399	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	556	0	0	0	0	0	0	0	0	556	5
6	Maintenance	0	0	1,162	3,483	0	0	0	0	0	0	0	4,645	6
7	Other (specify):*	0	0	0	326	0	0	0	0	0	0	0	326	7
8	TOTAL General Services	0	0	2,344	3,809	0	0	0	0	0	0	0	6,153	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	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	1,164	6,624	0	0	0	0	0	0	0	7,788	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(10,895)	7,250	(111,677)	0	0	0	0	0	0	0	0	(115,322)	19
20	Fees, Subscriptions & Promotions	(10,807)	0	378	0	0	0	0	0	0	0	0	(10,429)	20
21	Clerical & General Office Expenses	(395,266)	400	2,344	40,138	0	0	0	0	0	0	0	(352,384)	21
22	Employee Benefits & Payroll Taxes	0	0	0	(2,017)	0	0	0	0	0	0	0	(2,017)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	59	0	0	0	0	0	0	0	0	59	24
25	Other Admin. Staff Transportation	0	0	402	0	0	0	0	0	0	0	0	402	25
26	Insurance-Prop.Liab.Malpractice	0	0	697	0	0	0	0	0	0	0	0	697	26
27	Other (specify):*	0	0	0	9,146	0	0	0	0	0	0	0	9,146	27
28	TOTAL General Administration	(416,968)	7,650	(106,633)	53,891	0	0	0	0	0	0	0	(462,060)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(416,968)	7,650	(104,289)	57,700	0	0	0	0	0	0	0	(455,907)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rushville Nsg & Rehab Ctr # 0053637 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	177,620	929	0	0	0	0	0	0	0	0	178,549	30
31	Amortization of Pre-Op. & Org.	(2,457)	2,457	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(51)	68,710	3,371	0	0	0	0	0	0	0	0	72,030	32
33	Real Estate Taxes	0	(1,499)	1,624	0	0	0	0	0	0	0	0	125	33
34	Rent-Facility & Grounds	0	(260,714)	0	0	0	0	0	0	0	0	0	(260,714)	34
35	Rent-Equipment & Vehicles	0	0	380	0	0	0	0	0	0	0	0	380	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(2,508)	(13,426)	6,304	0	0	0	0	0	0	0	0	(9,630)	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)	(419,476)	(5,776)	(97,985)	57,700	0	0	0	0	0	0	0	(465,537)	45

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	\$ 260,714	Rushville Healthcare Properties, LLC	100.00%	\$	\$ (260,714)	1
2	V	32	Interest		Rushville Healthcare Properties, LLC	100.00%			2
3	V	19	Professional Fees		Rushville Healthcare Properties, LLC	100.00%	7,250	7,250	3
4	V	21	Office		Rushville Healthcare Properties, LLC	100.00%	400	400	4
5	V	26	Property Insurance		Rushville Healthcare Properties, LLC	100.00%			5
6	V	30	Depreciation		Rushville Healthcare Properties, LLC	100.00%	177,620	177,620	6
7	V	31	Amortization		Rushville Healthcare Properties, LLC	100.00%	2,457	2,457	7
8	V	32	Interest		Rushville Healthcare Properties, LLC	100.00%	68,710	68,710	8
9	V	33	Real Estate Taxes	40,445	Rushville Healthcare Properties, LLC	100.00%	38,946	(1,499)	9
10	V	36	Mortgage Insurance Premiums		Rushville Healthcare Properties, LLC	100.00%			10
11	V								11
12	V								12
13	V								13
14	Total			\$ 301,159			\$ 295,383	\$ * (5,776)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Rushville Nsg & Rehab Ctr

0053637

Report Period Beginning:

01/01/16

Ending:

12/31/16

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Sherwin Ray	60.00%	Beecher Manor Nursing and Rehab	Beecher, IL	Ex. Care Consulting	Evanston, IL	Home Office	1
2	Atied Associates, LLC	40.00%	Briar Place	Indian Head, IL	Ex. Care Clinical	Evanston, IL	Administrative	2
3			Chateau Village Nursing and Rehab	Willowbrook, IL	2201 Main Street	Evanston, IL	Bldg. Company	3
4			Grasmere Place	Chicago, IL	CCS VEBA	Evanston, IL	Health Insurance	4
5			Lakewood Nursing and Rehab	Plainfield, IL	Vent Lease	Evanston, IL	Vent. Rental	5
6			Lemont Nursing and Rehab	Lemont, IL	Mac RX, LLC	Des Plaines, IL	Pharmacy	6
7			Prairie Manor Halth Care	Chicago Heights, IL	Reliable Medical	Des Plaines, IL	Medical Supply	7
8			Rainbow Beach Nursing Center	Chicago, IL				8
9			Sheridan Shores	Chicago, IL				9
10			South Suburban Rehabilitation Center	Chicago, IL				10
11			Tri-State Nursing and Rehab	Lansing, IL				11
12			Wheaton Care Center	Wheaton, IL	Rushville HC			12
13			Kensington Place Nursing and Rehab	Chicago, IL	Properties, LLC	Evanston, IL	Bldg. Company	13
14			Countryside Nursing and Rehab	Dolton, IL				14
15			Spring Creek Nursing and Rehab	Joliet, IL				15
16			Park House Nursing and Rehab	Chicago, IL				16
17			Timber Point Healthcare Center	Camp Point, IL				17
18			Prairie Village Healthcare Center	Jacksonville, IL				18
19			Major Hospital - Dyer	Dyer, IN				19
20			Major Hospital - Lake County	East Chicago, IN				20
21			Major Hospital - Sebo	Holbart, IN				21
22			Major Hospital - Lincolnshire	Merrillville, IN				22
23			Major Hospital - Munster	Munster, IN				23
24			McKinley Health Care Center	Canton, OH				24
25			St. James Manor	Crete, IL				25
26			St. James Manor - Assisted Living	Crete, IL				26
27			The Parc at Joliet	Joliet, IL				27
28			The Estates of Hyde Park	Chicago, IL				28
29			Rushville Nursing and Rehab	Rushville, IL				29
30			Paramount of Oak Park	Oak Park, IL				30

SEE ACCOUNTANTS' PREPARATION REPORT

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			Sheffield Manor Assisted Living	Dyer, IN				1
2			Kenosha Estates	Kenosha, WI				2
3			Milwaukee Estates	Milwaukee, WI				3
4			Appleton	Appleton, WI				4
5								5
6								6
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28								28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

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. ☒ 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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	\$	Extended Care Consulting, LLC	100.00%	\$ 72	\$ 72	15
16	V	2	Food		Extended Care Consulting, LLC	100.00%	155	155	16
17	V	3	Housekeeping		Extended Care Consulting, LLC	100.00%	399	399	17
18	V	5	Utilities		Extended Care Consulting, LLC	100.00%	556	556	18
19	V	6	Maintenance		Extended Care Consulting, LLC	100.00%	1,162	1,162	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	1,164	1,164	20
21	V	19	Professional Fees	114,000	Extended Care Consulting, LLC	100.00%	2,323	(111,677)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	378	378	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	2,344	2,344	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	59	59	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	402	402	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	697	697	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	929	929	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	3,371	3,371	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	1,624	1,624	29
30	V	35	Rent - Equipment and Auto		Extended Care Consulting, LLC	100.00%	380	380	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			\$ 114,000			\$ 16,015	\$ * (97,985)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

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.

☒

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	Maintenance (Pooled)	\$	Extended Care Consulting, LLC	100.00%	\$ 3,483	\$	3,483
16	V	6	Maintenance (Direct)		Extended Care Consulting, LLC	100.00%	0		
17	V	7	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	326		326
18	V	7	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	0		
19	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	6,624		6,624
20	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	40,138		40,138
21	V	21	Office and Clerical (Direct)	6,724	Extended Care Consulting, LLC	100.00%	6,724		
22	V	27	Emp. Gen. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	8,553		8,553
23	V	27	Emp. Gen. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	593		593
24	V	22	Employee Benefits	2,017	Extended Care Consulting, LLC	100.00%			(2,017)
25	V								
26	V								
27	V								
28	V								
29	V								
30	V								
31	V								
32	V								
33	V								
34	V								
35	V								
36	V								
37	V								
38	V								
39	Total			\$ 8,741			\$ 66,441	\$ *	57,700

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

SEE ACCOUNTANTS' PREPARATION REPORT

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. ☒ 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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Employee Benefits	\$ 100,297	CCS VEBA	100.00%	\$ 100,297	\$	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			\$ 100,297			\$ 100,297	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI. SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Rushville Nsg & Rehab Ctr # 0053637 Report Period Beginning: 01/01/16 Ending: 12/31/16

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Sherwin Ray	Shareholder	Administration	60.00%	See Attached	7.00	17.50%	Salary	\$ 39,981	17 - 01	1
2	Adam Vales	Relative	Clerical	0.00%	See Attached	0.51	1.27%	Alloc. Salary	935	22 - 07	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 40,916		13

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Page 7 Supplemental Schedule

Description	Alloc. Hours	Total Hours	Alloc. Percentage	Total Compensation			Alloc. Compensation	
				Salary	Mgmt. Fees		Salary	Mgmt. Fees
Owners / Director Compensation								
Sherwin Ray							-	-
Prairie Village Healthcare Center	7.88	40.00	19.70%	228,468	-		45,008	-
Timber Point Healthcare Center	7.88	40.00	19.70%	228,468	-		45,008	-
Rushville Nursing & Rehab Center	7.00	40.00	17.50%	228,468	-		39,982	-
Countryside Nursing & Rehab Center	17.24	40.00	43.10%	228,468	-		98,470	-
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Rushville Nsg & Rehab Ctr
Medicaid Cost Report
01/01/16 - 12/31/16

Page 7 Supplemental Schedule

Description	Alloc. Hours	Total Hours	Alloc. Percentage	Total Compensation			Alloc. Compensation	
				Salary	Mgmt. Fees		Salary	Mgmt. Fees
Owners / Director Compensation								
Adam Vales							-	-
Prairie Village Healthcare Center	0.42	40.00	1.04%	73,410	-		762	-
Timber Point Healthcare Center	0.85	40.00	2.12%	73,410	-		1,556	-
Rushville Nursing & Rehab Center	0.51	40.00	1.27%	73,410	-		935	-
Countryside Nursing & Rehab Center	1.29	40.00	3.21%	73,410	-		2,360	-
Kensington Nursing & Rehab Center	0.86	40.00	2.14%	73,410	-		1,572	-
Park House Nursing & Rehab Center	0.63	40.00	1.57%	73,410	-		1,151	-
Other Insured Entities	35.46	40.00	88.65%	73,410	-		65,075	-
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Facility Name & ID Number Rushville Nsg & Rehab Ctr # 0053637 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

- A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒
- B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Rushville Healthcare Properties, LLC
Street Address 2201 Main Street
City / State / Zip Code Evanston, Illinois 60202
Phone Number ()
Fax Number ()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
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22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Rushville Nsg & Rehab Ctr # 0053637 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Extended Care Consulting, LLC
Street Address 2201 Main Street
City / State / Zip Code Evanston, Illinois 60202
Phone Number (847) 905 - 3000
Fax Number (847) 491 - 9565

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	1	Dietary	Patient Days	1,380,761	34	\$ 5,206	\$	19,126	\$ 72	1
2	2	Food	Patient Days	1,380,761	34	11,203		19,126	155	2
3	3	Housekeeping	Patient Days	1,380,761	34	28,798		19,126	399	3
4	5	Utilities	Patient Days	1,380,761	34	40,168		19,126	556	4
5	6	Maintenance	Patient Days	1,380,761	34	83,922		19,126	1,162	5
6	17	Administrative	Patient Days	1,380,761	34	84,000		19,126	1,164	6
7	19	Professional Fees	Patient Days	1,380,761	34	167,697		19,126	2,323	7
8	20	Dues and Subscriptions	Patient Days	1,380,761	34	27,266		19,126	378	8
9	21	Office and Clerical	Patient Days	1,380,761	34	169,235		19,126	2,344	9
10	24	Travel and Seminar	Patient Days	1,380,761	34	4,279		19,126	59	10
11	25	Other Staff Admin. Trans.	Patient Days	1,380,761	34	29,053		19,126	402	11
12	26	Insurance	Patient Days	1,380,761	34	50,289		19,126	697	12
13	30	Depreciation	Patient Days	1,380,761	34	67,038		19,126	929	13
14	32	Interest	Patient Days	1,380,761	34	243,379		19,126	3,371	14
15	33	Real Estate Taxes	Patient Days	1,380,761	34	117,233		19,126	1,624	15
16	35	Rent - Equipment and Auto	Patient Days	1,380,761	34	27,451		19,126	380	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,156,217	\$		\$ 16,015	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Rushville Nsg & Rehab Ctr # 0053637 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Extended Care Consulting, LLC
Street Address 2201 Main Street
City / State / Zip Code Evanston, Illinois 60202
Phone Number (847) 905 - 3000
Fax Number (847) 941 - 9565

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	6	Maintenance	Patient Days	1,380,761	34	\$ 251,431	\$ 251,431	19,126	\$ 3,483	1
2	6	Maintenance	Direct	373,682	34	373,682	373,682			2
3	7	Emp. Ben. - Gen. Serv.	Patient Days	1,380,761	34	23,565		19,126	326	3
4	7	Emp. Ben. - Gen. Serv.	Direct	46,748	34	46,748				4
5	17	Administrative	Patient Days	1,380,761	34	478,172	478,172	19,126	6,624	5
6	21	Office and Clerical	Patient Days	1,380,761	34	2,897,656	2,897,656	19,126	40,138	6
7	21	Office and Clerical	Direct	460,382	34	460,382	460,382	6,724	6,724	7
8	27	Emp. Gen. - Gen. Admin.	Patient Days	1,380,761	34	617,434		19,126	8,553	8
9	27	Emp. Gen. - Gen. Admin.	Direct	73,413	34	73,413		593	593	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					\$ 5,222,483	\$ 4,461,323		\$ 66,441	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Rushville Nsg & Rehab Ctr # 0053637 Report Period Beginning: 01/01/16 Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization CCS VEBA
Street Address 2201 Main Street
City / State / Zip Code Evanston, Illinois 60202
Phone Number (847) 905 - 3000
Fax Number (847) 491 - 9565

	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	22	Employee Benefits	Direct Allocation	7,877,989		\$ 7,877,989	\$	100,297	\$ 100,297	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					\$ 7,877,989	\$		\$ 100,297	25

SEE ACCOUNTANTS' PREPARATION REPORT

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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Heartland Bank and Trust		X	Mortgage			\$	1,456,684			\$	68,710	1
2													2
3													3
4													4
5													5
	Working Capital												
6	Alloc. - Extended Care		X									3,371	6
7													7
8													8
9	TOTAL Facility Related						\$	1,456,684			\$	72,081	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13	Interest Income		X									(51)	13
14	TOTAL Non-Facility Related						\$				\$	(51)	14
15	TOTALS (line 9+line14)						\$	1,456,684			\$	72,030	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 0 Line # N/A

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2015 report.		\$	42,255	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.)		\$	41,234	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	(1,021)	3	
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	41,590	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.		\$	40,569	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2011		8	
		2012		9	
		2013		10	
		2014		11	
		2015	39,610	12	
2016 Real Estate Tax Accrual = \$39,610 * 1.05 = \$41,590				13	
Alloc. - Extended Care Consulting, LLC = \$1,624				14	
				15	
				16	

		FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	\$		13
14	PLUS APPEAL COST FROM LINE 5	\$		14
15	LESS REFUND FROM LINE 6	\$		15
16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' PREPARATION REPORT

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rushville Nsg & Rehab Ctr COUNTY Schuyler

FACILITY IDPH LICENSE NUMBER 0053637

CONTACT PERSON REGARDING THIS REPORT Edward N. Slack, CPA

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	08 - 30 - 451 - 008	Long Term Care Facility	\$ 308.36	\$ 308.36
2.	08 - 30 - 379 - 004	Long Term Care Facility	\$ 58.92	\$ 58.92
3.	08 - 30 - 451 - 006	Long Term Care Facility	\$ 445.08	\$ 445.08
4.	08 - 30 - 377 - 011	Long Term Care Facility	\$ 71.56	\$ 71.56
5.	08 - 30 - 379 - 003	Long Term Care Facility	\$ 194.28	\$ 194.28
6.	08 - 30 - 377 - 012	Long Term Care Facility	\$ 396.30	\$ 396.30
7.	08 - 30 - 451 - 007	Long Term Care Facility	\$ 1,611.52	\$ 1,611.52
8.	08 - 30 - 379 - 001	Long Term Care Facility	\$ 176.02	\$ 176.02
9.	08 - 30 - 379 - 002	Long Term Care Facility	\$ 215.14	\$ 215.14
10.	08 - 30 - 376 - 044	Long Term Care Facility	\$ 247.28	\$ 247.28
		TOTALS	\$ 3,724.46	\$ 3,724.46

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation . Facilities located in Cook County are required to providecopies of their original second installment tax bill.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2015 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rushville Nsg & Rehab Ctr COUNTY Schuyler
FACILITY IDPH LICENSE NUMBER 0053637
CONTACT PERSON REGARDING THIS REPORT Edward N. Slack, CPA
TELEPHONE (847) 628 - 8796 FAX #: (248) 327 - 8417

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

	(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
	Tax Index Number	Property Description	Total Tax	
1.	Prior Page Sub - Total	Long Term Care Facility	\$ 3,724.46	\$ 3,724.46
2.			\$	\$
3.	08 - 30 - 377 - 009	Long Term Care Facility	\$ 35,594.24	\$ 35,594.24
4.	08 - 30 - 377 - 010	Long Term Care Facility	\$ 290.80	\$ 290.80
5.	Alloc. - Ext. Care Consulting	Long Term Care Facility	\$ 167,518.13	\$ 1,623.89
6.	Alloc. - Ext. Care Consulting	Long Term Care Facility	\$ 36,794.68	\$ 356.68
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 243,922.31	\$ 41,590.07

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original second installment tax bill.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 46,354

B. General Construction Type: Exterior Brick Frame Steel

Number of Stories 2

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (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?

☒ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☒ (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		2015	\$ 171,881	1
2	Alloc. - Ext. Care			7,949	2
3	TOTALS			\$ 179,830	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Rushville Nsg & Rehab Ctr

0053637

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	99		2015	1966	\$ 1,428,751	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Architecture Planning			2015	3,220						9
10	Window Coverings - Blinds (Resident Rooms)			2016	3,054						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

*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

SEE ACCOUNTANTS' PREPARATION REPORT

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									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,435,025	\$		\$	\$	\$	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12A, Carried Forward		\$ 1,435,025	\$		\$	\$	\$	1
2								2
3 Related Party Allocations - See Supplemental Schedules								3
4								4
5 Allocations - Extended Care Consulting, LLC	2007	64						5
6 Allocations - Extended Care Consulting, LLC	2009	38						6
7 Allocations - Extended Care Consulting, LLC	2010	374						7
8 Allocations - Extended Care Consulting, LLC	2011	135						8
9 Allocations - Extended Care Consulting, LLC	2013	44						9
10 Allocations - Extended Care Consulting, LLC	2014	614						10
11 Allocations - Extended Care Consulting, LLC	2016	737						11
12								12
13 Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2002	10,954						13
14 Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2002	9,049						14
15 Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2003	10,664						15
16 Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2005	530						16
17 Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2009	96						17
18 Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2014	889						18
19 Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2015	151						19
20 Allocations - Extended Care Consulting, LLC / 2201 Main, LLC	2016	595						20
21								21
22 Allocations - Extended Care Consulting, LLC / Dyer Building	2007	3,324						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)		\$ 1,473,283	\$		\$	\$	\$	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

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		\$ 1,473,283	\$		\$	\$	\$	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									25
26									26
27									27
28									28
29									29
30	Depreciation - Rushville Nursing & Rehabilitation Center, LLC			6,111		6,111		6,218	30
31	Depreciation - Rushville Healthcare Properties, LLC			177,620		177,620		234,879	31
32	Depreciation - Extended Care Consulting, LLC			929		929		71,809	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,473,283	\$ 184,660		\$ 184,660	\$	\$ 312,906	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

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	\$	\$	\$	\$		\$	71
72	Current Year Purchases	6,773						72
73	Fully Depreciated Assets							73
74	See Supplemental	365,847						74
75	TOTALS	\$ 372,620	\$	\$	\$		\$	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	Alloc. - Extended Care			\$ 2,500	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$ 2,500	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$ 2,028,233	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 184,660	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 184,660	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 312,906	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.

SEE ACCOUNTANTS' PREPARATION REPORT

Rushville Nsg & Rehab Ctr
Medicaid Cost Report
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Page 13 - Related Party Furniture and Equipment Allocations

[illegible]

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? ☐ YES ☐ NO
- If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	See Suppl				0			5
6								6
7	TOTAL				\$			7

10. Effective dates of current rental agreement:

Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2017	\$
13.	/2018	\$
14.	/2019	\$

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: *

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: \$ 12,036 Description: See Supplemental Schedule
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Rushville Nsg & Rehab Ctr
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Page 14 Supplemental Schedule

Description		Amount		Total
Building Rental				
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
Total		-		-
Equipment Rental				
Ecolab		1,052		1,052
Watts Copy Systems		5,761		5,761
Richards Electric Motor Co		3,159		3,159
Great American Financial Services		1,441		1,441
Other		243		243
				-
				-
Alloc. - Extended Care Consulting, LLC		380		380
				-
				-
				-
				-
				-
				-
Total		12,036		12,036

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

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' PREPARATION REPORT

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

		1	2		3	4	5	6	7	8				
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)					
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	140,523	\$		\$	140,523	1		
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				26,154				26,154	2		
3	Licensed Recreational Therapist		hrs									3		
4	Licensed Physical Therapist	39 - 03	hrs				139,665				139,665	4		
5	Physician Care		visits									5		
6	Dental Care		visits									6		
7	Work Related Program		hrs									7		
8	Habilitation		hrs									8		
9	Pharmacy	39 - 02	# of prescrpts					76,860			76,860	9		
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10		
	Academic Education		hrs									11		
12	Other (specify): See Supplemental	39 - 02						17,802			17,802	12		
13	Other (specify): See Supplemental	39 - 03					24,822				24,822	13		
14	TOTAL				\$		\$	331,164	\$	94,662		\$	425,826	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Rushville Nsg & Rehab Ctr
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Page 16 Supplemental Schedule

[illegible]

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 15,325	\$ 66,470	1
2	Cash-Patient Deposits	5,579	5,579	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 430,326)	823,342	823,342	3
4	Supply Inventory (priced at Cost - FIFO)			4
5	Short-Term Investments			5
6	Prepaid Insurance	66,893	66,893	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Supplemental Schedule	36,248	16,504	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 947,387	\$ 978,788	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		171,881	13
14	Buildings, at Historical Cost		1,259,903	14
15	Leasehold Improvements, at Historical Cost	3,220	172,068	15
16	Equipment, at Historical Cost	9,827	330,222	16
17	Accumulated Depreciation (book methods)	(6,218)	(241,097)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental Schedule		8,600	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 6,829	\$ 1,701,577	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 954,216	\$ 2,680,365	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 632,186	\$ 632,186	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	5,825	5,825	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	95,183	95,183	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,509	4,509	31
32	Accrued Real Estate Taxes(Sch.IX-B)	41,590	41,590	32
33	Accrued Interest Payable		5,732	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule	1,064,616	1,009,779	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,843,909	\$ 1,794,804	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,456,684	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 1,456,684	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,843,909	\$ 3,251,488	46
47	TOTAL EQUITY(page 18, line 24)	\$ (889,692)	\$ (571,122)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 954,217	\$ 2,680,366	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

Rushville Nsg & Rehab Ctr
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Page 17 Supplemental Schedule

Description		Operating		Building		Total
Line 9 - Other Current Assets						
Escrow - Real Estate Taxes		36,248		(19,744)		16,504
						-
						-
						-
						-
Sub-Total		36,248		(19,744)		16,504
Line 23 - Long Term Assets						
Financing Fees (Net of Amortization)				8,600		8,600
						-
						-
						-
						-
Sub-Total		-		8,600		8,600
Line 36 - Other Current Liability						
Due to Rushville Healthcare Partners		228,820		(228,820)		-
Due to Prior Owners		25,161				25,161
Due to Affiliated Entities		810,635		173,983		984,618
						-
						-
Sub-Total		1,064,616		(54,837)		1,009,779
Line 43 - Long term Liabilities						
						-
						-
						-
						-
						-
Sub-Total		-		-		-

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (408,119)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (408,119)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(481,573)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (481,573)	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)	\$ (889,692)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Rushville Nsg & Rehab Ctr

0053637

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,328,730	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,328,730	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	91,074	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 91,074	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	1,200	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,200	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	51	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 51	26
	E. Other Revenue (specify).****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	444	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 444	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,421,499	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	690,822	31
32	Health Care	1,080,262	32
33	General Administration	1,228,663	33
	B. Capital Expense		
34	Ownership	318,925	34
	C. Ancillary Expense		
35	Special Cost Centers	425,826	35
36	Provider Participation Fee	158,574	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,903,072	40
41	Income before Income Taxes (line 30 minus line 40)**	(481,573)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (481,573)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,239,930	44
45	Private Pay - Net Inpatient Revenue	948,438	45
46	Medicare - Net Inpatient Revenue	1,087,204	46
47	Other-(specify) <u>Insurance - Net Patient Revenue</u>	243	47
48	Other-(specify) <u>Hospice - Net Patient Revenue</u>	52,915	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,328,730	49

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Rushville Nsg & Rehab Ctr
Medicaid Cost Report
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Page 19 Supplemental Schedule

[illegible]

Facility Name & ID Number Rushville Nsg & Rehab Ctr# 0053637

Report Period Beginning:

01/01/16

Ending:

12/31/16

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,984	2,023	\$ 62,435	\$ 30.86	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,482	8,034	217,638	27.09	3
4	Licensed Practical Nurses	9,409	10,129	190,240	18.78	4
5	CNAs & Orderlies	38,509	41,351	434,385	10.50	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	376	446	8,938	20.04	8
9	Activity Director	1,826	1,929	19,899	10.32	9
10	Activity Assistants	1,839	1,963	18,251	9.30	10
11	Social Service Workers	846	847	9,073	10.71	11
12	Dietician					12
13	Food Service Supervisor	2,075	2,192	38,897	17.74	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,311	15,733	146,344	9.30	15
16	Dishwashers					16
17	Maintenance Workers	5,654	6,047	67,400	11.15	17
18	Housekeepers	5,627	6,174	55,957	9.06	18
19	Laundry	3,902	4,278	39,035	9.12	19
20	Administrator	2,091	2,137	72,111	33.74	20
21	Assistant Administrator					21
22	Other Administrative	364	364	39,981	109.84	22
23	Office Manager					23
24	Clerical	6,232	6,641	116,626	17.56	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	2,165	2,290	66,990	29.25	33
34	TOTAL (lines 1 - 33)	104,692	112,578	\$ 1,604,200 *	\$ 14.25	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$ 5,496	01 - 03	35
36	Medical Director		2,400	09 - 03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		1,999	10 - 03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		792	11 - 03	44
45	Social Service Consultant		1,749	12 - 03	45
46	Other(specify)				46
47	<u>See Supplemental Schedule</u>				47
48					48
49	TOTAL (lines 35 - 48)		\$ 12,436		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	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

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

Rushville Nsg & Rehab Ctr
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Page 20 Supplemental Schedule

Description	CC Reference	Hours Worked	Hours Paid	Salary	Average Rate	Hours Paid	Contracted Cost
Nursing Home Employees							
MDS / Care Plan Coordinator	10	2,165	2,290	66,990	29.25		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
Total		2,165	2,290	66,990	29.25		

Contracted Services							
N/A							
Total						-	-

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount		Description	Amount
Melissa Conover	Administrator	0	\$ 72,111	Workers' Compensation Insurance	\$	42,581	IDPH License Fee	\$ 1,990
Sherwin Ray	Administration	60.00%	39,981	Unemployment Compensation Insurance		10,545	Advertising: Employee Recruitment	3,850
				FICA Taxes		118,422	Health Care Worker Background Check	
				Employee Health Insurance		68,301	(Indicate # of checks performed)	1,818
				Employee Meals			Patient Background Checks	
				Illinois Municipal Retirement Fund (IMRF)*			Dues - ICLTC	14,044
				Other Employee Benefits		7,267	Dues and Subscriptions	793
				Page 6B - Employee Benefit Offset		(2,017)	Licenses and Fees	2,179
TOTAL (agree to Schedule V, line 17, col. 1)							Advertising and Promotion	10,807
(List each licensed administrator separately.)			\$ 112,092				Alloc. - Extended Care Consulting	378
B. Administrative - Other							Less: Public Relations Expense	()
Description			Amount				Non-allowable advertising	(10,807)
			\$				Yellow page advertising	()
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V, line 22, col.8)	\$	245,099	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 25,052
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type		Amount					
Extended Care Consulting	Management Fee		\$ 114,000				Out-of-State Travel	\$
Plante & Moran, PLLC	Accounting		12,600					
Marcum, LLP	Accounting		1,200					
Personnel Planners	Unemployment Consultant		1,506				In-State Travel	
Matrixcare	Data Processing / IT		12,453					
Ability Network	Data Processing / IT		4,622					
National Data Corporation	Data Processing / IT		1,595					
Paycor Payroll Services	Data Processing / IT		12,077				Seminar Expense	4,288
E Health Data Solutions	Data Processing / IT		484				Alloc. - Extended Care Consulting	59
Cass Communications	Data Processing / IT		1,696					
Other	Data Processing / IT		5,749					
See Supplemental Schedule			9,413				Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V, line 24, col. 8)	
(For legal fee disclosure, see page 39 of instructions)			\$ 177,395				TOTAL	\$ 4,347

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

Rushville Nsg & Rehab Ctr
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Page 21 Supplemental Schedule - Other Professional Fees

[illegible]

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 - \$14,044

(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 Yrs

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 6,474

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.

\$ 158,574

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?

No

Indicate the amount. \$ 0

(16) Travel and Transportation

a. Are there costs included for out-of-state travel?

No

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

No

If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A

c. What percent of all travel expense relates to transportation of nurses and patients?

N/A

d. Have vehicle usage logs been maintained?

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. N/A

Attach invoices and a summary of services for all architect and appraisal fees

SEE ACCOUNTANTS' PREPARATION REPORT

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