

		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>0047423</u> Facility Name: <u>Cisne Rehab & Hlth Care Ctr</u> Address: <u>107 N Watkins Bx 370</u> <u>Cisne</u> <u>62823</u> Number City Zip Code County: <u>Wayne</u> Telephone Number: <u>(618) 673-2177</u> Fax # <u>(618) 673-2309</u> HFS ID Number: _____ Date of Initial License for Current Owners: <u>10/1/2005</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> In the event there are further questions about this report, please contact: Name: <u>Mike Kocher</u> Telephone Number: <u>(309) 673-3009</u> Email Address: _____	☐ 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 _____		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2016</u> to <u>12/31/2016</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. <table><tr><td rowspan="2">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td rowspan="6">Paid Preparer</td><td>(Type or Print Name) <u>Mark B. Petersen</u></td></tr><tr><td>(Title) <u>Chief Executive Officer</u></td></tr><tr><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) _____</td></tr><tr><td></td><td>(Telephone) <u>()</u> Fax # <u>()</u></td></tr><tr><td colspan="2"> 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 </td></tr></table>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	Paid Preparer	(Type or Print Name) <u>Mark B. Petersen</u>	(Title) <u>Chief Executive Officer</u>	(Signed) _____	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) _____		(Telephone) <u>()</u> Fax # <u>()</u>	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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Facility Name & ID Number Cisne Rehab & Hlth Care Ctr

0047423 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	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>11</u>	Skilled (SNF)	<u>11</u>	<u>4,015</u>	<u>1</u>
2		Skilled Pediatric (SNF/PED)			<u>2</u>
3	<u>24</u>	Intermediate (ICF)	<u>24</u>	<u>8,760</u>	<u>3</u>
4		Intermediate/DD			<u>4</u>
5		Sheltered Care (SC)			<u>5</u>
6		ICF/DD 16 or Less			<u>6</u>
7	<u>35</u>	TOTALS	<u>35</u>	<u>12,775</u>	<u>7</u>

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>2,645</u>	<u>1,370</u>	<u>4,015</u>	<u>8</u>
9	SNF/PED					<u>9</u>
10	ICF	<u>6,628</u>	<u>6</u>		<u>6,634</u>	<u>10</u>
11	ICF/DD					<u>11</u>
12	SC					<u>12</u>
13	DD 16 OR LESS					<u>13</u>
14	TOTALS	<u>6,628</u>	<u>2,651</u>	<u>1,370</u>	<u>10,649</u>	<u>14</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.36%

D. How many bed-hold days during this year were paid by the Department? None (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) 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 ☒ 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 10/1/2005

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 10/1/2005 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter number of beds certified 11 and days of care provided 1,370

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number Cisne Rehab & Hlth Care Ctr # 0047423 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	98,569	7,569	1,605	107,743		107,743	2,187	109,930			1
2	Food Purchase		70,940		70,940		70,940	(7,850)	63,090			2
3	Housekeeping	37,605	9,845		47,450		47,450	38	47,488			3
4	Laundry	18,918	4,634		23,552		23,552		23,552			4
5	Heat and Other Utilities			26,726	26,726		26,726	127	26,853			5
6	Maintenance	30,428	7,893	17,047	55,368		55,368	1,509	56,877			6
7	Other (specify):* Home Office Ben. Allocation											7
8	TOTAL General Services	185,520	100,881	45,378	331,779		331,779	(3,989)	327,790			8
	B. Health Care and Programs											
9	Medical Director			8,400	8,400		8,400		8,400			9
10	Nursing and Medical Records	573,219	57,207	9,961	640,387		640,387	(877)	639,510			10
10a	Therapy		60	178,851	178,911		178,911		178,911			10a
11	Activities	37,903	92	301	38,296		38,296	(5,396)	32,900			11
12	Social Services	23,059			23,059		23,059		23,059			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Office Ben. Allocation											15
16	TOTAL Health Care and Programs	634,181	57,359	197,513	889,053		889,053	(6,273)	882,780			16
	C. General Administration											
17	Administrative			179,100	179,100		179,100	(145,023)	34,077			17
18	Directors Fees											18
19	Professional Services			(197)	(197)		(197)	15,783	15,586			19
20	Dues, Fees, Subscriptions & Promotions			3,395	3,395		3,395	233	3,628			20
21	Clerical & General Office Expenses		2,464	8,832	11,296		11,296	25,655	36,951			21
22	Employee Benefits & Payroll Taxes			92,488	92,488		92,488	14,259	106,747			22
23	Inservice Training & Education			200	200		200	49	249			23
24	Travel and Seminar							24	24			24
25	Other Admin. Staff Transportation			3,434	3,434		3,434	2,006	5,440			25
26	Insurance-Prop.Liab.Malpractice			9,261	9,261		9,261	9,437	18,698			26
27	Other (specify):* Home Office Ben. Allocation											27
28	TOTAL General Administration		2,464	296,513	298,977		298,977	(77,577)	221,400			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	819,701	160,704	539,404	1,519,809		1,519,809	(87,839)	1,431,970			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.

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			586	586		586	25,172	25,758			30
31	Amortization of Pre-Op. & Org.							6,498	6,498			31
32	Interest							48,806	48,806			32
33	Real Estate Taxes							14,006	14,006			33
34	Rent-Facility & Grounds			136,971	136,971		136,971	(136,971)				34
35	Rent-Equipment & Vehicles			12,778	12,778		12,778	459	13,237			35
36	Other (specify):*											36
37	TOTAL Ownership			150,335	150,335		150,335	(42,030)	108,305			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		46,213		46,213		46,213		46,213			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			75,498	75,498		75,498		75,498			42
43	Other (specify):*		346	18,132	18,478		18,478	(18,478)				43
44	TOTAL Special Cost Centers		46,559	93,630	140,189		140,189	(18,478)	121,711			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	819,701	207,263	783,369	1,810,333		1,810,333	(148,347)	1,661,986			45

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

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	(1,785)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,735)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	3,372	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(89)	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	(6,166)	43		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				24
25	Fund Raising, Advertising and Promotional	(1,821)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(20,183)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (29,407)		\$	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)	(119,379)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (119,379)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (148,786)		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Disallowed Special Events	\$ (325)	43	1
2	Offset Meals on Wheels Revenue	(6,105)	2	2
3	Offset Miscellaneous Office Supplies Revenue	(73)	21	3
4	Resident Flowers	(144)	43	4
5	Labs-Part A	(3,846)	43	5
6	X-Rays-Part A	(3,352)	43	6
7	Offset Transportation Revenue	(5,396)	11	7
8	Offset Miscellaneous Nursing Supplies Revenue	(942)	10	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	(20,183)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Cisne Rehab & Hlth Care Ctr# 0047423

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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	2,187	0	0	0	0	0	0	0	0	0	2,187	1
2	Food Purchase	(7,890)	40	0	0	0	0	0	0	0	0	0	(7,850)	2
3	Housekeeping	0	38	0	0	0	0	0	0	0	0	0	38	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	127	0	0	0	0	0	0	0	0	0	127	5
6	Maintenance	0	1,194	0	0	315	0	0	0	0	0	0	1,509	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(7,890)	3,586	0	0	315	0	0	0	0	0	0	(3,989)	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	(942)	65	0	0	0	0	0	0	0	0	0	(877)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(5,396)	0	0	0	0	0	0	0	0	0	0	(5,396)	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	(6,338)	65	0	0	0	0	0	0	0	0	0	(6,273)	16
	C. General Administration													
17	Administrative	0	(145,462)	0	0	0	0	0	0	0	0	0	(145,462)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	5,570	0	5,893	4,320	0	0	0	0	0	0	15,783	19
20	Fees, Subscriptions & Promotions	0	0	233	0	0	0	0	0	0	0	0	233	20
21	Clerical & General Office Expenses	(73)	0	25,500	0	228	0	0	0	0	0	0	25,655	21
22	Employee Benefits & Payroll Taxes	0	0	14,259	0	0	0	0	0	0	0	0	14,259	22
23	Inservice Training & Education	0	0	49	0	0	0	0	0	0	0	0	49	23
24	Travel and Seminar	0	0	24	0	0	0	0	0	0	0	0	24	24
25	Other Admin. Staff Transportation	0	0	2,006	0	0	0	0	0	0	0	0	2,006	25
26	Insurance-Prop.Liab.Malpractice	0	0	283	0	9,154	0	0	0	0	0	0	9,437	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(73)	(139,892)	42,354	5,893	13,702	0	0	0	0	0	0	(78,016)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(14,301)	(136,241)	42,354	5,893	14,017	0	0	0	0	0	0	(88,278)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Cisne Rehab & Hlth Care Ctr # 0047423 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	3,372	0	5,643	712	15,445	0	0	0	0	0	0	25,172	30
31	Amortization of Pre-Op. & Org.	0	0	0	1,304	5,194	0	0	0	0	0	0	6,498	31
32	Interest	0	0	166	8,880	39,760	0	0	0	0	0	0	48,806	32
33	Real Estate Taxes	0	0	130	0	13,876	0	0	0	0	0	0	14,006	33
34	Rent-Facility & Grounds	0	0	0	0	(136,971)	0	0	0	0	0	0	(136,971)	34
35	Rent-Equipment & Vehicles	0	0	459	0	0	0	0	0	0	0	0	459	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	3,372	0	6,398	10,896	(62,696)	0	0	0	0	0	0	(42,030)	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):*	(18,478)	0	0	0	0	0	0	0	0	0	0	(18,478)	43
44	TOTAL Special Cost Centers	(18,478)	0	0	0	0	0	0	0	0	0	0	(18,478)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(29,407)	(136,241)	48,752	16,789	(48,679)	0	0	0	0	0	0	(148,786)	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
Mark B. Petersen	100	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.

☒ 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	1	Dietary	\$	Petersen Health Care Management, Inc.	100.00%	\$ 2,187	\$ 2,187	1
2	V	2	Food		Petersen Health Care Management, Inc.	100.00%	40	40	2
3	V	3	Housekeeping		Petersen Health Care Management, Inc.	100.00%	38	38	3
4	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	127	127	4
5	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	1,194	1,194	5
6	V	7	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		6
7	V	9	Medical Director		Petersen Health Care Management, Inc.	100.00%	0		7
8	V	10	Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	65	65	8
9	V	10A	Therapy		Petersen Health Care Management, Inc.	100.00%	0		9
10	V	15	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		10
11	V	17	Administrative	179,100	Petersen Health Care Management, Inc.	100.00%	33,638	(145,462)	11
12	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	5,570	5,570	12
13	V								13
14	Total			\$ 179,100			\$ 42,859	\$ * (136,241)	14

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

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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	20 <u>Dues, Fees, Subs & Promotions</u>	\$	<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	\$ <u>233</u>	\$ <u>233</u>	15
16	V	21 <u>Clerical and General Office</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>25,500</u>	<u>25,500</u>	16
17	V	22 <u>Employee Benefits and Payroll Taxes</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>14,259</u>	<u>14,259</u>	17
18	V	23 <u>Inservice Training & Education</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>49</u>	<u>49</u>	18
19	V	24 <u>Travel and Seminar</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>24</u>	<u>24</u>	19
20	V	25 <u>Other Admin. Staff Transport.</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>2,006</u>	<u>2,006</u>	20
21	V	26 <u>Insurance-Prop./Liab./Malprac.</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>283</u>	<u>283</u>	21
22	V	27 <u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>0</u>		22
23	V	30 <u>Depreciation</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>5,643</u>	<u>5,643</u>	23
24	V	32 <u>Interest</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>166</u>	<u>166</u>	24
25	V	33 <u>Real Estate Taxes</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>130</u>	<u>130</u>	25
26	V	35 <u>Rent-Equipment & Vehicles</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>459</u>	<u>459</u>	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		\$			\$ <u>48,752</u>	\$ * <u>48,752</u>	39

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

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	\$	Petersen Health Operations, LLC	100.00%	\$ 0	\$	15
16	V	2	Food		Petersen Health Operations, LLC	100.00%	0		16
17	V	3	Housekeeping		Petersen Health Operations, LLC	100.00%	0		17
18	V	4	Laundry		Petersen Health Operations, LLC	100.00%	0		18
19	V	5	Utilities		Petersen Health Operations, LLC	100.00%	0		19
20	V	6	Maintenance		Petersen Health Operations, LLC	100.00%	0		20
21	V	7	Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	0		21
22	V	10	Nursing and Medical Records		Petersen Health Operations, LLC	100.00%	0		22
23	V	15	Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	0		23
24	V	17	Administrative		Petersen Health Operations, LLC	100.00%	0		24
25	V	19	Professional Services		Petersen Health Operations, LLC	100.00%	5,893	5,893	25
26	V	20	Dues, Fees, Subs & Promotions		Petersen Health Operations, LLC	100.00%	0		26
27	V	21	Clerical and General Office		Petersen Health Operations, LLC	100.00%	0		27
28	V	22	Employee Benefits & Payroll		Petersen Health Operations, LLC	100.00%	0		28
29	V	23	Inservice Training & Education		Petersen Health Operations, LLC	100.00%	0		29
30	V	24	Travel and Seminar		Petersen Health Operations, LLC	100.00%	0		30
31	V	25	Other Admin. Staff Transport.		Petersen Health Operations, LLC	100.00%	0		31
32	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Operations, LLC	100.00%	0		32
33	V	30	Depreciation		Petersen Health Operations, LLC	100.00%	712	712	33
34	V	31	Amortization		Petersen Health Operations, LLC	100.00%	1,304	1,304	34
35	V	32	Interest		Petersen Health Operations, LLC	100.00%	8,880	8,880	35
36	V	33	Real Estate Taxes		Petersen Health Operations, LLC	100.00%	0		36
37	V	34	Rent-Facility and Grounds		Petersen Health Operations, LLC	100.00%	0		37
38	V	35	Rent-Equipment & Vehicles		Petersen Health Operations, LLC	100.00%	0		38
39	Total			\$			\$ 16,789	\$ * 16,789	39

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

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	\$	Cisne Land, LLC	100.00%	\$ 315	\$	315 15
16	V	19	Professional Services	\$	Cisne Land, LLC	100.00%	\$ 4,320	\$	4,320 16
17	V	21	Equipment		Cisne Land, LLC	100.00%	228		228 17
18	V	26	Insurance-Property		Cisne Land, LLC	100.00%	2,311		2,311 18
19	V	26	Insurance-Mortgage Insurance		Cisne Land, LLC	100.00%	6,843		6,843 19
20	V	30	Depreciation		Cisne Land, LLC	100.00%	15,445		15,445 20
21	V	31	Amortization		Cisne Land, LLC	100.00%	5,194		5,194 21
22	V	32	Interest	774	Cisne Land, LLC	100.00%	40,534		39,760 22
23	V	33	Real Estate Taxes		Cisne Land, LLC	100.00%	13,876		13,876 23
24	V	34	Rent-Income and Grounds	136,971	Cisne Land, LLC	100.00%			(136,971) 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			\$ 137,745			\$ 89,066	\$ *	(48,679) 39

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

Facility Name & ID Number

Cisne Rehab & Hlth Care Ctr

0047423

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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			Aledo Health Care Center	Aledo	Petersen Companies, I	Peoria	Mgmt/Bookkeeping	1
2			Arcola Health Care Center	Arcola	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	2
3			Aspen Rehab & Health Care	Silvis	Petersen Health Care,	Peoria	Mgmt/Bookkeeping	3
4			Batavia Rehab & Health Care Center	Batavia	Petersen Health Enter	Peoria	Mgmt/Bookkeeping	4
5			Bement Health Care Center	Bement	Petersen Health Opera	Peoria	Mgmt/Bookkeeping	5
6			Benton Rehab & Health Care Center	Benton	Petersen Health Syste	Peoria	Mgmt/Bookkeeping	6
7			Bloomington Rehab & Health Care Center	Bloomington	Petersen Hotels LLC	Peoria	Hospitality	7
8			Casey Health Care Center	Casey	Petersen Hospitality L	Peoria	Hospitality	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Management	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Busin	Peoria	Mgmt/Bookkeeping	11
12			Countryview Terrace	Louisville	Petersen Health Care	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care	Peoria	Lessor	13
14			Decatur Rehab & Health Care Center	Decatur	Midwest Health Opera	Peoria	Mgmt/Bookkeeping	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Health Prope	Peoria	Mgmt/Bookkeeping	15
16			Eastview Terrace	Sullivan	Petersen Roseville, LL	Roseville	Lessor	16
17			El Paso Health Care Center	El Paso	Petersen Health Juncti	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Petersen Health Qualit	Peoria	Mgmt/Bookkeeping	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Health and W	Peoria	Mgmt/Bookkeeping	19
20			Flanagan Rehab & Health Care Center	Flanagan	Petersen 24, LLC	Peoria	Hospitality	20
21			Flora Gardens Care Center	Flora				21
22			Flora Health Care Center	Flora				22
23			Fondulac Rehab & Health Care Center	East Peoria				23
24			Havana Health Care Center	Havana				24
25			Illini Heritage Rehab & Health Care	Champaign				25
26			Jonesboro Rehab & Health Care Center	Jonesboro				26
27			Kewanee Care Home	Kewanee				27
28			LaHarpe Davier Health Care Center	LaHarpe				28
29			Lebanon Care Center	Lebanon				29
30			Marigold Rehab & Health Care Center	Galesburg				30

Facility Name & ID Number

Cisne Rehab & Hlth Care Ctr

0047423

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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			Mason Point	Sullivan				1
2			McLeansboro Rehab & Health Care Center	McLeansboro				2
3			Mt. Vernon Health Care Center	Mt. Vernon				3
4			Newman Rehab & Health Care Center	Newman				4
5			Nokomis Rehab & Health Care Center	Nokomis				5
6			North Aurora Care Center	North Aurora				6
7			Palm Terrace of Mattoon	Mattoon				7
8			Piper City Rehab & Living Center	Piper City				8
9			Pleasant View Rehab & Health Care Center	Morrison				9
10			Polo Rehabilitation & Health Care Center	Polo				10
11			Prairie City Rehab & Health Care Center	Prairie City				11
12			Robings Manor Nursing Home	Brighton				12
13			Rochelle Gardens	Rochelle				13
14			Rochelle Rehab & Health Care Center	Rochelle				14
15			Rock Falls Rehab & Health Care Center	Rock Falls				15
16			Arrow Wood Independent Living	Rock Falls				16
17			Roseville Rehab and Health Care Center	Roseville				17
18			Rosiclare Rehab & Health Care Center	Rosiclare				18
19			Royal Oaks Care Center	Kewanee				19
20			Sandwich Rehab & Health Care Center	Sandwich				20
21			Iron Wood Independent Living	Sandwich				21
22			Shawnee Rose Care Center	Harrisburg				22
23			Shelbyville Rehab & Health Care Center	Shelbyville				23
24			South Elgin Rehab & Health Care Center	South Elgin				24
25			Sullivan Health Care Center	Sullivan				25
26			Sunset Manor Nursing Home	Canton				26
27			Swansea Rehab & Health Care	Swansea				27
28			Timbercreek Rehab & Health Center	Pekin				28
29			Toulon Health Care Center	Toulon				29
30			Tuscola Health Care Center	Tuscola				30

Facility Name & ID Number

Cisne Rehab & Hlth Care Ctr

0047423

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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			Twin Lakes Rehab & Health Care Center	Paris				1
2			Vandalia Rehab & Health Care Center	Vandalia				2
3			Watseka Health Care Center	Watseka				3
4			Westside Rehab & Care Center	West Frankfort				4
5			Whispering Oaks	Rosiclare				5
6			White Oak Rehab & Health Care Center	Mt. Vernon				6
7			Willow Rose Rehab & Health Care Center	Jerseyville				7
8			Sheldon Health Care Center	Sheldon				8
9			Tuscola Health Care Center	Tuscola				9
10			Effingham Health Care Center	Effingham				10
11			Collinsville Health Care Center	Collinsville				11
12			Ozark Rehab & Health Care Center	Osage Beach, MO				12
13			Tarkio Rehab & Health Care Center	Tarkio, MO				13
14			Shangri-la Rehab & Living Center	Blue Springs, MO				14
15			Prairie Rose Care Center	Pana				15
16			Illini Heritage Rehab & Health Center	Champaign				16
17			Courtyard Estates of Kewanee	Kewanee				17
18			Courtyard Estates of Bradford	Bradford				18
19			Courtyard Estates of Galva	Galva				19
20			Courtyard Estates of Walcott	Walcott				20
21			Courtyard Village of Kewanee	Kewanee				21
22			Lakewood Village	Charleston				22
23			Courtyard Estates of Monmouth	Monmouth				23
24			Riverview Estates	Havana				24
25			Simple Blessings	Casey				25
26			Courtyard Estates of Bushnell	Bushnell				26
27			Courtyard Estates of Canton	Canton				27
28			Legacy Estates of Monmouth	Monmouth				28
29			Courtyard Estates of Sullivan	Sullivan				29
30			Courtyard Estates of Peoria	Peoria				30

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			Cornerstone Health and Rehabilitation	Peoria				1
2			Rock River Gardens	Sterling				2
3			Sauk Valley Senior Living & Rehabilitation	Rock Falls				3
4			Courtyard Estates of Farmington	Farmington				4
5			Courtyard Estates of Knoxville	Knoxville				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

Facility Name & ID Number Cisne Rehab & Hlth Care Ctr # 0047423 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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									\$		1
2											2
3	N/A										3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number Cisne Rehab & Hlth Care Ctr# 0047423

Report Period Beginning:

1/1/2016Ending: 2/31/2016

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

Petersen Health Care Management, Inc.

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309) 691-8113

Fax Number

(309) 691-8622

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, Square Feet)	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference				Allocated Among	Allocated	in Column 6			
1	1	Dietary	Resident Days	75	\$ 312,540	\$ 357,910	10,649	\$ 2,187	1
2	2	Food	Resident Days	75	5,673	0	10,649	40	2
3	3	Housekeeping	Resident Days	75	5,456	2,897	10,649	38	3
4	5	Utilities	Resident Days	75	18,209	0	10,649	127	4
5	6	Maintenance	Resident Days	75	170,632	137,057	10,649	1,194	5
6	7	Mgmt. Allocation of Benefits	Resident Days	75	0	0	10,649	0	6
7	9	Medical Director	Resident Days	75	0	0	10,649	0	7
8	10	Nursing and Medical Records	Resident Days	75	9,261	1,782,521	10,649	65	8
9	10A	Therapy	Resident Days	75	0	0	10,649	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	75	0	0	10,649	0	10
11	17	Administrative	Resident Days	75	4,806,228	5,473,961	10,649	33,638	11
12	19	Professional Services	Resident Days	75	795,918	0	10,649	5,570	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	75	33,278	0	10,649	233	13
14	21	Clerical and General Office	Resident Days	75	3,643,535	3,756,135	10,649	25,500	14
15	22	Employee Benefits and Payroll Ta	Resident Days	75	2,037,314	0	10,649	14,259	15
16	23	Inservice Training & Education	Resident Days	75	6,986	0	10,649	49	16
17	24	Travel and Seminar	Resident Days	75	3,389	0	10,649	24	17
18	25	Other Admin. Staff Transport.	Resident Days	75	286,637	0	10,649	2,006	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	75	40,378	0	10,649	283	19
20	27	Mgmt. Allocation of Benefits	Resident Days	75	0	0	10,649	0	20
21	30	Depreciation	Resident Days	75	806,271	0	10,649	5,643	21
22	32	Interest	Resident Days	75	23,686	0	10,649	166	22
23	33	Real Estate Taxes	Resident Days	75	18,560	0	10,649	130	23
24	35	Rent-Equipment & Vehicles	Resident Days	75	65,550	0	10,649	459	24
25	TOTALS				\$ 13,089,501	\$ 11,510,481		\$ 91,611	25

Facility Name & ID Number Cisne Rehab & Hlth Care Ctr# 0047423

Report Period Beginning:

1/1/2016Ending: 2/31/2016

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

Petersen Health Operations, LLC

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309)691-8113

Fax Number

(309)691-8622

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6			
1	1	Dietary	Resident Days	197,666	9	\$	\$	10,649	\$	1
2	2	Food	Resident Days	197,666	9			10,649		2
3	3	Housekeeping	Resident Days	197,666	9			10,649		3
4	4	Laundry	Resident Days	197,666	9			10,649		4
5	5	Utilities	Resident Days	197,666	9			10,649		5
6	6	Maintenance	Resident Days	197,666	9			10,649		6
7	7	Mgmt. Allocation of Benefits	Resident Days	197,666	9			10,649		7
8	10	Nursing and Medical Records	Resident Days	197,666	9			10,649		8
9	15	Mgmt. Allocation of Benefits	Resident Days	197,666	9			10,649		9
10	17	Administrative	Resident Days	197,666	9			10,649		10
11	19	Professional Services	Resident Days	197,666	9	109,392		10,649	5,893	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	197,666	9			10,649		12
13	21	Clerical and General Office	Resident Days	197,666	9			10,649		13
14	22	Employee Benefits & Payroll	Resident Days	197,666	9			10,649		14
15	23	Inservice Training & Education	Resident Days	197,666	9			10,649		15
16	24	Travel and Seminar	Resident Days	197,666	9			10,649		16
17	25	Other Admin. Staff Transport.	Resident Days	197,666	9			10,649		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	197,666	9			10,649		18
19	30	Depreciation	Resident Days	197,666	9	13,207		10,649	712	19
20	31	Amortization	Resident Days	197,666	9	24,205		10,649	1,304	20
21	32	Interest	Resident Days	197,666	9	164,836		10,649	8,880	21
22	33	Real Estate Taxes	Resident Days	197,666	9			10,649		22
23	34	Rent-Facility and Grounds	Resident Days	197,666	9			10,649		23
24	35	Rent-Equipment & Vehicles	Resident Days	197,666	9			10,649		24
25	TOTALS					\$ 311,640	\$		\$ 16,789	25

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	Capital Finance Group		X	Mortgage	Varies	1/1/2015	\$ 1,118,500	\$ 1,034,548	12/31/2024	Varies	\$ 40,534	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$ 1,118,500	\$ 1,034,548			\$ 40,534	9
	B. Non-Facility Related*											
10								Interest Income Offset			(774)	10
11								Home Office Allocation-PHO			8,880	11
12								Home Office Allocation-PHCM			166	12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ 8,272	14
15	TOTALS (line 9+line14)						\$ 1,118,500	\$ 1,034,548			\$ 48,806	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ 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.)

** 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

[illegible]

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.

FACILITY NAME Cisne Rehab & Hlth Care Ctr COUNTY Wayne
FACILITY IDPH LICENSE NUMBER 0047423
CONTACT PERSON REGARDING THIS REPORT MIKE KOCHER
TELEPHONE (309)689-5850 FAX #: (309)691-8622

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.

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

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.

A. Square Feet: 9,413

B. General Construction Type: Exterior Brick VeneerFrame WoodNumber of Stories 1

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).

N/A

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: 157,125

2. Number of Years Over Which it is Being Amortized: 20

3. Current Period Amortization: 6,498

4. Dates Incurred: 2013-2014

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	75,359	2005	\$ 9,000	1
2					2
3	TOTALS	75,359		\$ 9,000	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	35		2005	1970	\$ 186,500	\$	25	\$ 7,060	\$ 7,060	\$ 86,859
5										
6										
7										
8										
	Improvement Type**									
9	Waterline		2005		1,634		15	109	109	1,253
10	Sewer Line		2007		3,500		20	175	175	1,663
11	Condenser Unit		2009		5,018		7	358	358	5,018
12	Sprinkler System Repair		2011		3,799		7	542	542	2,981
13	Sewer Line Repair		2013		4,926		7	704	704	2,464
14	Canopy Replacement		2014		3,093		15	206	206	515
15	Landscaping		2014		18,811		15	1,254	1,254	3,135
16	Nursing Call Station		2016		5,261		7	376	376	376
17	Parking Lot Resurfacing		2016		38,210		15	1,274	1,274	1,274
18	Back Patio Repair		2016		4,406		7	315	315	315
19	Sidewalk Ramp		2016		3,000		15	100	100	100
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30	Land Improvements Booked					1,009			(1,009)	
31	Building Booked					7,090			(7,090)	
32	Building Improvement Booked					5,019			(5,019)	
33										
34	2016-Home Office Allocation-Building Improvements				4,702			113	113	
35	2016-Home Office Allocation-Land Improvements				433			28	28	
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 Cisne Rehab & Hlth Care Ctr

0047423

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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)		\$ 283,293	\$ 13,118		\$ 12,614	\$ (504)	\$ 105,953	70

**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	\$22,535	\$1,554	\$2,252	\$698	5-10 yrs.	\$14,533	71
72	Current Year Purchases	18,279	1,131	1,306	175	7 yrs.	1,306	72
73	Fully Depreciated Assets	39,452					39,452	73
74	Home Office Allocation			6,214	6,214			74
75	TOTALS	\$80,266	\$2,685	\$9,772	\$7,087		\$55,291	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	2010 Ford Van	2010	\$28,001	\$	\$2,801	\$	5 yrs.	\$28,001
77	Facility	2010 Ford Van Repair	2016	3,426	286	571	285	3 yrs.	571
78									
79									
80	TOTALS			\$31,427	\$286	\$3,372	\$285		\$28,572

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)			\$403,986	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$16,089	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$25,758	
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$6,868	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$189,816	

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		\$	\$	
87				
88	N/A			
89				
90				
91	TOTALS	\$	\$	

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94	N/A	
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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. YES NO

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

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

15. Is Movable equipment rental included in building rental? X YES NO
16. Rental Amount for movable equipment: \$ 13,237 Description: See Attached Schedule 14A
(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	N/A				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.

Cisne Rehab & Hlth Care Ctr
0047423

Period Beginning 1/1/2016
Period End 12/31/2016

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$	7,080
Dishwasher		1,373
Copier		4,325
Home Office Allocation		459
		<u>13,237</u>

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

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

		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)	\$			

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		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	10A(3)	hrs	\$	4,981	\$ 74,719	\$	4,981	\$ 74,719	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2,218	33,268		2,218	33,268	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		4,724	70,864	60	4,724	70,924	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				46,213		46,213	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	11,923	\$ 178,851	\$ 46,273	11,923	\$ 225,124	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.				
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	\$ 95,538	\$ 95,538	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 63,780)	525,056	525,056	3
4	Supply Inventory (priced at Cost)	4,944	4,944	4
5	Short-Term Investments			5
6	Prepaid Insurance	10,248	15,984	6
7	Other Prepaid Expenses		11,022	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 635,786	\$ 652,544	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		9,000	13
14	Buildings, at Historical Cost		191,202	14
15	Leasehold Improvements, at Historical Cost	7,406	92,091	15
16	Equipment, at Historical Cost	32,638	111,693	16
17	Accumulated Depreciation (book methods)	(28,587)	(189,816)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		103,883	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(11,687)	20
21	Restricted Funds		219,036	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 11,457	\$ 525,402	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 647,243	\$ 1,177,946	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 301,496	\$ 301,496	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	41,021	41,021	30
31	Accrued Taxes Payable (excluding real estate taxes)	17,511	17,511	31
32	Accrued Real Estate Taxes(Sch.IX-B)		13,824	32
33	Accrued Interest Payable		3,319	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	142,493	142,493	36
37	Accrued Management Fees	25,352	25,352	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 527,873	\$ 545,016	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,034,548	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Intercompany Loans	544,539	(40,609)	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 544,539	\$ 993,939	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,072,412	\$ 1,538,955	46
47	TOTAL EQUITY(page 18, line 24)	\$ (425,169)	\$ (361,009)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 647,243	\$ 1,177,946	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (804,720)	1
2	Restatements (describe):		2
3	Prior Period Adjustments Made After Cost Report Was Filed	(1,454)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (806,174)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	337,078	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	43,927	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)	\$ 381,005	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)	\$ (425,169)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Cisne Rehab & Hlth Care Ctr

0047423

Report Period Beginning: 1/1/2016

Ending: 12/31/2016

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	\$ 1,817,370	1
2	Discounts and Allowances for all Levels	(90,597)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,726,773	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	320,678	6
7	Oxygen	246	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 320,924	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	7,890	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	74,616	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	7,423	20
21	Other Medical Services	3,374	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 93,303	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Transportation Revenue</u>	5,396	28
28a	<u>Miscellaneous Revenue</u>	1,015	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 6,411	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,147,411	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	331,779	31
32	Health Care	889,053	32
33	General Administration	298,977	33
	B. Capital Expense		
34	Ownership	150,335	34
	C. Ancillary Expense		
35	Special Cost Centers	64,691	35
36	Provider Participation Fee	75,498	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,810,333	40
41	Income before Income Taxes (line 30 minus line 40)**	337,078	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 337,078	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,003,807	44
45	Private Pay - Net Inpatient Revenue	402,563	45
46	Medicare - Net Inpatient Revenue	320,403	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 1,726,773	49

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

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

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	2,584	2,727	\$ 66,482	\$ 24.38	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,579	5,768	106,437	18.45	3
4	Licensed Practical Nurses	6,133	6,415	93,447	14.57	4
5	CNAs & Orderlies	19,071	19,371	264,664	13.66	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,969	2,017	25,548	12.67	9
10	Activity Assistants	124	124	1,135	9.15	10
11	Social Service Workers	1,842	1,874	23,059	12.30	11
12	Dietician					12
13	Food Service Supervisor	1,014	1,014	14,751	14.55	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,500	8,964	83,818	9.35	15
16	Dishwashers					16
17	Maintenance Workers	1,975	2,039	30,428	14.92	17
18	Housekeepers	2,832	3,091	37,605	12.17	18
19	Laundry	1,776	1,924	18,918	9.83	19
20	Administrator	2,080	2,080	34,077	16.38	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					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 <u>CPC</u>	1,736	1,736	42,189	24.30	32
33	Other(specify) <u>Transportation</u>	1,282	1,282	11,220	8.75	33
34	TOTAL (lines 1 - 33)	58,497	60,426	\$ 853,778 *	\$ 14.13	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	27	\$ 1,605	L1, C3	35
36	Medical Director	Monthly	8,400	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant			L10, C3	38
39	Pharmacist Consultant	Monthly	2,294	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	\$ 12,299		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

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

** See instructions.

Facility Name & ID Number		Cisne Rehab & Hlth Care Ctr		STATE OF ILLINOIS		# 0047423		Report Period Beginning:		1/1/2016		Page 21		Ending: 12/31/2016	
XIX. SUPPORT SCHEDULES															
A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions							
Name		Function		Ownership		Description		Amount		Description		Amount			
Jennifer Wheat		Administrator		0		Workers' Compensation Insurance		\$ 12,261		IDPH License Fee		\$			
Pamela Mix-Bissey		Administrator		0		Unemployment Compensation Insurance		19,720		Advertising: Employee Recruitment		171			
						FICA Taxes		56,991		Health Care Worker Background Check					
						Employee Health Insurance		2,604		(Indicate # of checks performed 3)		62			
						Employee Meals				Patient Background Checks		23 451			
						Illinois Municipal Retirement Fund (IMRF)*				Miscellaneous Licenses & Permits		383			
						Employee Relations		555		Miscellaneous Dues & Subscriptions		2,328			
						Employee Retirement		357		Home Office Allocation		233			
						Home Office Allocation		14,259							
TOTAL (agree to Schedule V, line 17, col. 1)															
(List each licensed administrator separately.)				\$ 34,077											
B. Administrative - Other															
Description				Amount											
Management Fees-See Page 6, Eliminated on P 3, C 7				\$ 179,100											
TOTAL (agree to Schedule V, line 17, col. 3)				\$ 179,100											
(Attach a copy of any management service agreement)															
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**							
Vendor/Payee		Type		Amount		Description		Line #		Amount		Description		Amount	
Wabash Independent Networks		Computer Services		\$ 636						\$		Out-of-State Travel		\$	
E-Health Data Solutions		Computer Services		2,941											
Honkamp Krueger		Accounting Fees		434		N/A									
Ability Network		Computer Services		102								In-State Travel			
Wayne Co Circuit Clerk		Legal Fees		10											
Capital Finance Group		Refund of Refinance Fees		(4,320)											
												Seminar Expense			
												Home Office Allocation		24	
												Entertainment Expense		()	
TOTAL (agree to Schedule V, line 19, column 3)								TOTAL							
(For legal fee disclosure, see page 39 of instructions)				\$ (197)				\$				(agree to Sch. V, line 24, col. 8)			
												TOTAL			
												\$ 24			
								* Attach copy of IMRF notifications				**See instructions.			

Cisne Rehab & Hlth Care Ctr
0047423

Period Beginning
Period End

1/1/2016
12/31/2016

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		(197)
Home Office Allocation		
Lucie, Scalf, and Bougher	Legal	25
Miscellaneous	Legal	6
Miller Hall and Triggs	Legal	43
Healthcare Resources International	Legal	215
Hunziker Law	Legal	51
Lexis Nexis	Legal	4
Illinois Secretary of State	Legal	15
Lane and Waterman	Legal	88
Quinn and Johnston	Legal	390
Peoria County Recorder	Legal	11
Capital Finance Group	Legal	250
CliftonLarson Allen	Accountants	223
Ginoli & Co.	Accountants	7,174
Capital Finance Group	Accountants	699
Miscellaneous	Computer Services	28
Change Healthcare	Computer Services	4
PTC Select	Computer Services	3
Advanced Answers on Demand	Computer Services	1,961
Stratus Networks	Computer Services	200
Kemper Technology	Computer Services	131
AT&T	Computer Services	3
Ability Network	Computer Services	836
CIAN	Computer Services	100
Comcast	Computer Services	16
CCH	Computer Services	7
Charter Communications	Computer Services	19
Allscripts	Computer Services	292
ATS	Computer Services	132
Allpayer Exchange	Computer Services	7
Optimizer	Other Prof Fees	20
Ankura	Other Prof Fees	152
David Budde	Other Prof Fees	17
Bruner, Cooper, Zuck	Other Prof Fees	44
Marotta, Gund, Budd, Dzerda	Other Prof Fees	2,591
Professional Software and Services	Other Prof Fees	11
Hughes Valuation Services	Other Prof Fees	14
Alan Litwiller	Other Prof Fees	1

Total (agree to Schedule V, line 19, column 8)	<u>15,586</u>
--	---------------

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?
If YES, give association name and amount.

Yes
ICHA \$1000
- (3)

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

No
N/A
- (4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

No
N/A
- (5)

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

Yes
7 yrs.
- (6)

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

\$ 18,314 Line 10
- (7)

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

Yes
- (8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

No
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.
- (11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.
This amount is to be recorded on line 42 of Schedule V.

\$ 75,498
- (12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

No

- (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?
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.

No
- (15)

Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V.
Has any meal income been offset against related costs?

\$ 0
Yes
Indicate the amount. \$ 1,785
- (16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

No

b.

Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

Yes
\$ 5,396

c.

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

100

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?
Indicate the amount of income earned from providing such transportation during this reporting period.

No
\$ N/A

(17)

Has an audit been performed by an independent certified public accounting firm?
Firm Name:

Yes
Ginoli and Company

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

No

RECONCILIATION REPORT			Cisne Rehab & Hlth Car		02:37 PM	7/7/2017							
ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-148,786	equal to	-148,347	-439	FAILED	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	48,806	equal to	48,806	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	14,006	equal to	14,006	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	6,498	equal to	6,498	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	25,758	equal to	25,758	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	13,237	equal to	13,237	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to	0	0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	178,911	equal to	178,911	0	O.K.	Pg16 Z12+Z14..	N/A,B	1-4,40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv.- Supplies	46,273	equal to	46,273	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	331,779	equal to	331,779	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	889,053	equal to	889,053	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	298,977	equal to	298,977	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	150,335	equal to	150,335	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	64,691	equal to	64,691	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..,H24+I	N/A	38to41+43	4
Income Stat. Prov. Partic.	75,498	equal to	75,498	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	573,219	equal to	573,219	0	O.K.	Pg20 K11..,K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training		< or = to		#VALUE!	#VALUE!	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	37,903	equal to	37,903	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	23,059	equal to	23,059	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	98,569	equal to	98,569	0	O.K.	Pg20 K22..,K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	30,428	equal to	30,428	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	37,605	equal to	37,605	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	18,918	equal to	18,918	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	34,077	equal to	34,077	0	O.K.	Pg20 K30..,K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	0	equal to		#VALUE!	#VALUE!	Pg20 K33..,K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	853,778	equal to	819,701	34,077	FAILED	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	1,605	< or = to	1,605	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	8,400	< or = to	8,400	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	2,294	< or = to	9,961	-7,667	O.K.	Pg20 X14..,X16+	B. & C.	7to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to	301	-301	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	0	< or = to		0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	34,077	equal to	34,077	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	179,100	equal to	179,100	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	-197	equal to	-197	0	FAILED	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	106,747	equal to	106,747	0	FAILED	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	3,628	equal to	3,628	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	24	equal to	24	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	75,498	equal to	75,498	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..,U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	1,370	equal to	1,370	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	-119,379	equal to	-119,379	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4I	B.	14	8
Total loan balance	1,034,548	equal to	1,034,548	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27.	N/A	29+39-41	2
Real estate tax accrual	13,824	equal to	13,824	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	9,000	equal to	9,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	283,293	equal to	283,293	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	111,693	equal to	111,693	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	189,816	equal to	189,816	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	-425,169	equal to	-425,169	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	337,078	equal to	337,078	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..,I	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	647,243	equal to	647,243	0	O.K.	Pg17:H41	N/A	25	1	Pg17 S41	N/A	48	1

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Adjusted Total
1. Dietary	98,569	7,569	1,605	107,743	0	107,743	2,187	109,930
2. Food Purchase	0	70,940	0	70,940	0	70,940	-7,850	63,090
3. Housekeeping	37,605	9,845	0	47,450	0	47,450	38	47,488
4. Laundry	18,918	4,634	0	23,552	0	23,552	0	23,552
5. Heat and Other Utilities	0	0	26,726	26,726	0	26,726	127	26,853
6. Maintenance	30,428	7,893	17,047	55,368	0	55,368	1,509	56,877
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	185,520	100,881	45,378	331,779	0	331,779	-3,989	327,790
9. Medical Director	0	0	8,400	8,400	0	8,400	0	8,400
10. Nursing & Medical Records	573,219	57,207	9,961	640,387	0	640,387	-877	639,510
10a. Therapy	0	60	178,851	178,911	0	178,911	0	178,911
11. Activities	37,903	92	301	38,296	0	38,296	-5,396	32,900
12. Social Services	23,059	0	0	23,059	0	23,059	0	23,059
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	634,181	57,359	197,513	889,053	0	889,053	-6,273	882,780
17. Administrative	0	0	179,100	179,100	0	179,100	-145,023	34,077
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	-197	-197	0	-197	15,783	15,586
20. Fees, Subscriptions & Promotion	0	0	3,395	3,395	0	3,395	233	3,628
21. Clerical & General Office	0	2,464	8,832	11,296	0	11,296	25,655	36,951
22. Employee Benefits & Payroll	0	0	92,488	92,488	0	92,488	14,259	106,747
23. Inservice Training & Education	0	0	200	200	0	200	49	249
24. Travel and Seminar	0	0	0	0	0	0	24	24
25. Other Admin. Staff Trans	0	0	3,434	3,434	0	3,434	2,006	5,440
26. Insurance-Prop.Liab.Malpractice	0	0	9,261	9,261	0	9,261	9,437	18,698
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	0	2,464	296,513	298,977	0	298,977	-77,577	221,400
29. Total General Administrative	819,701	160,704	539,404	1,519,809	0	1,519,809	-87,839	#####
30. Depreciation	0	0	586	586	0	586	25,172	25,758
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	6,498	6,498
32. Interest	0	0	0	0	0	0	48,806	48,806
33. Real Estate	0	0	0	0	0	0	14,006	14,006
34. Rent - Facility & Grounds	0	0	136,971	136,971	0	136,971	-136,971	0
35. Rent - Equipment & Vehicles	0	0	12,778	12,778	0	12,778	459	13,237
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	150,335	150,335	0	150,335	-42,030	108,305
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	46,213	0	46,213	0	46,213	0	46,213
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	75,498	75,498	0	75,498	0	75,498
43. Other (specify):*	0	346	18,132	18,478	0	18,478	-18,478	0
44. Total Special Cost Ce	0	46,559	93,630	140,189	0	140,189	-18,478	121,711
45. Grand Total	819,701	207,263	783,369	1,810,333	0	1,810,333	-148,347	#####

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	95,538	95,538
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	525,056	525,056
4. Supply Inventory	4,944	4,944
5. Short-Term Investments	0	0
6. Prepaid Insurance	10,248	15,984
7. Other Prepaid Expenses	0	11,022
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	0	0
10. Total current assets	635,786	652,544
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	0	9,000
14. Buildings, at Historical Cost	0	191,202
15. Leasehold Improvements, Historical Cost	7,406	92,091
16. Equipment, at Historical Cost	32,638	111,693
17. Accumulated Depreciation (book methods)	-28,587	-189,816
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	103,883
20. Accum Amort - Org/Pre-Op Costs	0	-11,687
21. Restricted Funds	0	219,036
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	0
24. Total Long-Term Assets	11,457	525,402
25. Total Assets	647,243	1,177,946
CURRENT LIABILITIES		
26. Accounts Payable	301,496	301,496
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	41,021	41,021
31. Accrued Taxes Payable	17,511	17,511
32. Accrued Real Estate Taxes	0	13,824
33. Accrued Interest Payable	0	3,319
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	142,493	142,493
37. Other Current Liabilities (specify):	25,352	25,352
38. Total Current Liabilities	527,873	545,016
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	1,034,548
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	544,539	-40,609
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	544,539	993,939
46.Total Liabilities	1,072,412	1,538,955
47.Total Equity	-425,169	-361,009
48.Total Liabilities and Equity	647,243	1,177,946

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	1,817,370
2. Discounts and Allowances for all Levels	-90,597
Subtotal - Inpatient Care	1,726,773
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	320,678
7. Oxygen	246
Subtotal - Anciliary Revenue	320,924
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	7,890
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	74,616
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiology and X-Ray	7,423
21. Other Medical Services	3,374
22. Laundry	0
Subtotal - Other Operating Revenue	93,303
24. Contributions	0
25. Interest and Other Investments Income	0
Subtotal - Non-Operating Revenue	-
27. Other Revenue (specify):	5,396
28. Other Revenue (specify):	1,015
Subtotal - Other Revenue	6,411
30. Total Revenue	2,147,411
31. General Services	324,957
32. Health Care	836,448
33. General Administration	297,532
34. Ownership	143,112
35. Special Cost Centers	104,687
35. Provider Participation Fee	80,124
37. Other	0
40. Total Expenses	1,786,860
41. Income Before Income Taxes	360,551
42. Income Taxes	0
43. Net Income or Loss for the Year	360,551