

		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: 0053470

Facility Name: Collinsville Rehab & Hlth CC

Address: 614 North Summit Collinsville 62234
Number City Zip Code

County: Madison

Telephone Number: (618) 344-8476 Fax # (618) 344-8483

HFS ID Number:

Date of Initial License for Current Owners: 07/25/2006

Type of Ownership:

VOLUNTARY,NON-PROFIT
Charitable Corp.
Trust
IRS Exemption Code

X PROPRIETARY
Individual
Partnership
Corporation
"Sub-S" Corp.
X Limited Liability Co.
Trust
Other

GOVERNMENTAL
State
County
Other

In the event there are further questions about this report, please contact:
Name: Mike Kocher Telephone Number: (309) 673-3009
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2016 to 12/31/2016 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed)
(Type or Print Name) Mark B. Petersen
(Title) Chief Executive Officer

Paid Preparer

(Signed)
(Print Name and Title)
(Firm Name & Address)
(Telephone) () Fax # ()

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

Facility Name & ID Number Collinsville Rehab & Hlth CC

0053470 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>98</u>	Skilled (SNF)	<u>98</u>	<u>35,770</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>98</u>	TOTALS	<u>98</u>	<u>35,770</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>23,206</u>	<u>866</u>	<u>1,976</u>	<u>26,048</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>23,206</u>	<u>866</u>	<u>1,976</u>	<u>26,048</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.82%

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 7/25/2006

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 7/25/2006 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number of beds certified 98 and days of care provided 1,804

Medicare Intermediary Wisconsin Physicians Service

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 Collinsville Rehab & Hlth CC # 0053470 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	135,322	18,471		153,793		153,793	5,351	159,144			1
2	Food Purchase		155,598		155,598		155,598	(164)	155,434			2
3	Housekeeping	139,977	23,653		163,630		163,630	93	163,723			3
4	Laundry	20,453	12,703		33,156		33,156		33,156			4
5	Heat and Other Utilities			80,433	80,433		80,433	312	80,745			5
6	Maintenance	47,689	12,621	15,148	75,458		75,458	2,921	78,379			6
7	Other (specify):* <u>Home Office Ben. Allocation</u>											7
8	TOTAL General Services	343,441	223,046	95,581	662,068		662,068	8,513	670,581			8
	B. Health Care and Programs											
9	Medical Director			14,400	14,400		14,400		14,400			9
10	Nursing and Medical Records	1,104,902	119,705	7,156	1,231,763		1,231,763	(154)	1,231,609			10
10a	Therapy		266	249,927	250,193		250,193		250,193			10a
11	Activities	42,316	112	600	43,028		43,028	(1,250)	41,778			11
12	Social Services	37,595			37,595		37,595		37,595			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* <u>Home Office Ben. Allocation</u>											15
16	TOTAL Health Care and Programs	1,184,813	120,083	272,083	1,576,979		1,576,979	(1,404)	1,575,575			16
	C. General Administration											
17	Administrative			274,300	274,300		274,300	(216,300)	58,000			17
18	Directors Fees											18
19	Professional Services			27,517	27,517		27,517	27,426	54,943			19
20	Dues, Fees, Subscriptions & Promotions			6,887	6,887		6,887	570	7,457			20
21	Clerical & General Office Expenses	24,434	4,335	14,578	43,347		43,347	62,275	105,622			21
22	Employee Benefits & Payroll Taxes			201,627	201,627		201,627	34,878	236,505			22
23	Inservice Training & Education			(500)	(500)		(500)	120	(380)			23
24	Travel and Seminar							58	58			24
25	Other Admin. Staff Transportation			4,257	4,257		4,257	4,907	9,164			25
26	Insurance-Prop.Liab.Malpractice			29,831	29,831		29,831	691	30,522			26
27	Other (specify):* <u>Home Office Ben. Allocation</u>											27
28	TOTAL General Administration	24,434	4,335	558,497	587,266		587,266	(85,375)	501,891			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,552,688	347,464	926,161	2,826,313		2,826,313	(78,266)	2,748,047			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			88,089	88,089		88,089	16,012	104,101			30
31	Amortization of Pre-Op. & Org.							8,434	8,434			31
32	Interest			64,912	64,912		64,912	38,367	103,279			32
33	Real Estate Taxes			44,698	44,698		44,698	318	45,016			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			40,869	40,869		40,869	1,122	41,991			35
36	Other (specify):*											36
37	TOTAL Ownership			238,568	238,568		238,568	64,253	302,821			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		45,228		45,228		45,228		45,228			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			199,771	199,771		199,771		199,771			42
43	Other (specify):*		144	63,550	63,694		63,694	(63,694)				43
44	TOTAL Special Cost Centers		45,372	263,321	308,693		308,693	(63,694)	244,999			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,552,688	392,836	1,428,050	3,373,574		3,373,574	(77,707)	3,295,867			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	(261)	2		4
5	Telephone, TV & Radio in Resident Rooms	(11,393)	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	2,209	30		9
10	Interest and Other Investment Income	(701)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(24)	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	(19,400)	43		18
19	Entertainment				19
20	Contributions	(25)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(22,000)	43		24
25	Fund Raising, Advertising and Promotional	(1,299)	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	(11,216)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (64,110)		\$	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)	(13,597)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (13,597)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (77,707)		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	Labs-Part A	\$ (4,119)	43	1
2	X-Rays-Part A	(4,315)	43	2
3	Offset Transportation Revenue	(1,250)	11	3
4	Offset Miscellaneous Office Supplies Revenue	(100)	21	4
5	Disallowed Special Events	(794)	43	5
6	Offset Miscellaneous Nursing Supplies Revenue	(313)	10	6
7	Resident Flowers	(325)	43	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(11,216)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Collinsville Rehab & Hlth CC# 0053470

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	5,351	0	0	0	0	0	0	0	0	0	5,351	1
2	Food Purchase	(261)	97	0	0	0	0	0	0	0	0	0	(164)	2
3	Housekeeping	0	93	0	0	0	0	0	0	0	0	0	93	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	312	0	0	0	0	0	0	0	0	0	312	5
6	Maintenance	0	2,921	0	0	0	0	0	0	0	0	0	2,921	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(261)	8,774	0	0	0	0	0	0	0	0	0	8,513	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	(313)	159	0	0	0	0	0	0	0	0	0	(154)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(1,250)	0	0	0	0	0	0	0	0	0	0	(1,250)	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	(1,563)	159	0	0	0	0	0	0	0	0	0	(1,404)	16
	C. General Administration													
17	Administrative	0	(216,300)	0	0	0	0	0	0	0	0	0	(216,300)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	13,626	0	13,800	0	0	0	0	0	0	0	27,426	19
20	Fees, Subscriptions & Promotions	0	0	570	0	0	0	0	0	0	0	0	570	20
21	Clerical & General Office Expenses	(100)	0	62,375	0	0	0	0	0	0	0	0	62,275	21
22	Employee Benefits & Payroll Taxes	0	0	34,878	0	0	0	0	0	0	0	0	34,878	22
23	Inservice Training & Education	0	0	120	0	0	0	0	0	0	0	0	120	23
24	Travel and Seminar	0	0	58	0	0	0	0	0	0	0	0	58	24
25	Other Admin. Staff Transportation	0	0	4,907	0	0	0	0	0	0	0	0	4,907	25
26	Insurance-Prop.Liab.Malpractice	0	0	691	0	0	0	0	0	0	0	0	691	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(100)	(202,674)	103,599	13,800	0	0	0	0	0	0	0	(85,375)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,924)	(193,741)	103,599	13,800	0	0	0	0	0	0	0	(78,266)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Collinsville Rehab & Hlth CC # 0053470 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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	2,209	0	13,803	0	0	0	0	0	0	0	0	16,012	30
31	Amortization of Pre-Op. & Org.	0	0	0	8,434	0	0	0	0	0	0	0	8,434	31
32	Interest	(701)	0	406	38,662	0	0	0	0	0	0	0	38,367	32
33	Real Estate Taxes	0	0	318	0	0	0	0	0	0	0	0	318	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	1,122	0	0	0	0	0	0	0	0	1,122	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	1,508	0	15,649	47,096	0	0	0	0	0	0	0	64,253	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):*	(63,694)	0	0	0	0	0	0	0	0	0	0	(63,694)	43
44	TOTAL Special Cost Centers	(63,694)	0	0	0	0	0	0	0	0	0	0	(63,694)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(64,110)	(193,741)	119,248	60,896	0	0	0	0	0	0	0	(77,707)	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%	\$ 5,351	\$ 5,351	1
2	V	2	Food		Petersen Health Care Management, Inc.	100.00%	97	97	2
3	V	3	Housekeeping		Petersen Health Care Management, Inc.	100.00%	93	93	3
4	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	312	312	4
5	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	2,921	2,921	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%	159	159	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	274,300	Petersen Health Care Management, Inc.	100.00%	58,000	(216,300)	11
12	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	13,626	13,626	12
13	V								13
14	Total			\$ 274,300			\$ 80,559	\$ * (193,741)	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		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	20	Dues, Fees, Subs & Promotions	\$	Petersen Health Care Management, Inc.	100.00%	\$ 570	\$ 570	15
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	62,375	62,375	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	34,878	34,878	17
18	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	120	120	18
19	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	58	58	19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	4,907	4,907	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	691	691	21
22	V	27	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		22
23	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	13,803	13,803	23
24	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	406	406	24
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	318	318	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	1,122	1,122	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			\$			\$ 119,248	\$ * 119,248	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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	1 Dietary	\$	Petersen Health Business, LLC	100.00%	\$ 0	\$	15
16	V	2 Food		Petersen Health Business, LLC	100.00%	0		16
17	V	3 Housekeeping		Petersen Health Business, LLC	100.00%	0		17
18	V	4 Laundry		Petersen Health Business, LLC	100.00%	0		18
19	V	5 Utilities		Petersen Health Business, LLC	100.00%	0		19
20	V	6 Maintenance		Petersen Health Business, LLC	100.00%	0		20
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Business, LLC	100.00%	0		21
22	V	10 Nursing and Medical Records		Petersen Health Business, LLC	100.00%	0		22
23	V	15 Mgmt. Allocation of Benefits		Petersen Health Business, LLC	100.00%	0		23
24	V	17 Administrative		Petersen Health Business, LLC	100.00%	0		24
25	V	19 Professional Services		Petersen Health Business, LLC	100.00%	13,800	13,800	25
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Business, LLC	100.00%	0		26
27	V	21 Clerical and General Office		Petersen Health Business, LLC	100.00%	0		27
28	V	22 Employee Benefits & Payroll		Petersen Health Business, LLC	100.00%	0		28
29	V	23 Inservice Training & Education		Petersen Health Business, LLC	100.00%	0		29
30	V	24 Travel and Seminar		Petersen Health Business, LLC	100.00%	0		30
31	V	25 Other Admin. Staff Transport.		Petersen Health Business, LLC	100.00%	0		31
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Business, LLC	100.00%	0		32
33	V	30 Depreciation		Petersen Health Business, LLC	100.00%	0		33
34	V	31 Amortization		Petersen Health Business, LLC	100.00%	8,434	8,434	34
35	V	32 Interest		Petersen Health Business, LLC	100.00%	38,662	38,662	35
36	V	33 Real Estate Taxes		Petersen Health Business, LLC	100.00%	0		36
37	V	34 Rent-Facility and Grounds		Petersen Health Business, LLC	100.00%	0		37
38	V	35 Rent-Equipment & Vehicles		Petersen Health Business, LLC	100.00%	0		38
39	Total		\$			\$ 60,896	\$ * 60,896	39

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

Facility Name & ID Number

Collinsville Rehab & Hlth CC

0053470

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

Collinsville Rehab & Hlth CC

0053470

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

Collinsville Rehab & Hlth CC

0053470

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 Collinsville Rehab & Hlth CC # 0053470 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 Collinsville Rehab & Hlth CC# 0053470

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, 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	26,048	\$ 5,351	1
2	2	Food	Resident Days	75	5,673	0	26,048	97	2
3	3	Housekeeping	Resident Days	75	5,456	2,897	26,048	93	3
4	5	Utilities	Resident Days	75	18,209	0	26,048	312	4
5	6	Maintenance	Resident Days	75	170,632	137,057	26,048	2,921	5
6	7	Mgmt. Allocation of Benefits	Resident Days	75	0	0	26,048	0	6
7	9	Medical Director	Resident Days	75	0	0	26,048	0	7
8	10	Nursing and Medical Records	Resident Days	75	9,261	1,782,521	26,048	159	8
9	10A	Therapy	Resident Days	75	0	0	26,048	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	75	0	0	26,048	0	10
11	17	Administrative	Resident Days	75	4,806,228	5,473,961	26,048	58,000	11
12	19	Professional Services	Resident Days	75	795,918	0	26,048	13,626	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	75	33,278	0	26,048	570	13
14	21	Clerical and General Office	Resident Days	75	3,643,535	3,756,135	26,048	62,375	14
15	22	Employee Benefits and Payroll Tax	Resident Days	75	2,037,314	0	26,048	34,878	15
16	23	Inservice Training & Education	Resident Days	75	6,986	0	26,048	120	16
17	24	Travel and Seminar	Resident Days	75	3,389	0	26,048	58	17
18	25	Other Admin. Staff Transport.	Resident Days	75	286,637	0	26,048	4,907	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	75	40,378	0	26,048	691	19
20	27	Mgmt. Allocation of Benefits	Resident Days	75	0	0	26,048	0	20
21	30	Depreciation	Resident Days	75	806,271	0	26,048	13,803	21
22	32	Interest	Resident Days	75	23,686	0	26,048	406	22
23	33	Real Estate Taxes	Resident Days	75	18,560	0	26,048	318	23
24	35	Rent-Equipment & Vehicles	Resident Days	75	65,550	0	26,048	1,122	24
25	TOTALS				\$ 13,089,501	\$ 11,510,481		\$ 199,807	25

Facility Name & ID Number Collinsville Rehab & Hlth CC# 0053470

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 Business, 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	171,230	9	\$	\$	26,048	\$	1
2	2	Food	Resident Days	171,230	9			26,048		2
3	3	Housekeeping	Resident Days	171,230	9			26,048		3
4	4	Laundry	Resident Days	171,230	9			26,048		4
5	5	Utilities	Resident Days	171,230	9			26,048		5
6	6	Maintenance	Resident Days	171,230	9			26,048		6
7	7	Mgmt. Allocation of Benefits	Resident Days	171,230	9			26,048		7
8	10	Nursing and Medical Records	Resident Days	171,230	9			26,048		8
9	15	Mgmt. Allocation of Benefits	Resident Days	171,230	9			26,048		9
10	17	Administrative	Resident Days	171,230	9			26,048		10
11	19	Professional Services	Resident Days	171,230	9	90,714		26,048	13,800	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	171,230	9			26,048		12
13	21	Clerical and General Office	Resident Days	171,230	9			26,048		13
14	22	Employee Benefits & Payroll	Resident Days	171,230	9			26,048		14
15	23	Inservice Training & Education	Resident Days	171,230	9			26,048		15
16	24	Travel and Seminar	Resident Days	171,230	9			26,048		16
17	25	Other Admin. Staff Transport.	Resident Days	171,230	9			26,048		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	171,230	9			26,048		18
19	30	Depreciation	Resident Days	171,230	9			26,048		19
20	31	Amortization	Resident Days	171,230	9	55,441		26,048	8,434	20
21	32	Interest	Resident Days	171,230	9	254,149		26,048	38,662	21
22	33	Real Estate Taxes	Resident Days	171,230	9			26,048		22
23	34	Rent-Facility and Grounds	Resident Days	171,230	9			26,048		23
24	35	Rent-Equipment & Vehicles	Resident Days	171,230	9			26,048		24
25	TOTALS					\$ 400,304	\$		\$ 60,896	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	Bank Leumi		X	Mortgage	Varies	1/1/15	\$ 1,368,750	\$ 1,264,221	12/31/24	Varies	\$ 64,912	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 1,368,750	\$ 1,264,221			\$ 64,912	9	
	B. Non-Facility Related*												
10								Interest Income Offset			(701)	10	
11								Home Office Allocation-PHB			38,662	11	
12								Home Office Allocation-PHCM			406	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ 38,367	14	
15	TOTALS (line 9+line14)						\$ 1,368,750	\$ 1,264,221			\$ 103,279	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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Collinsville Rehab & Hlth CC COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0053470

CONTACT PERSON REGARDING THIS REPORT MIKE KOCHER

TELEPHONE (309)689-5850 FAX #: (309)691-8622

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</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
			<u>Nursing Home</u>
1. 13-2-21-28-18-303-001	Long-Term Care Facility	\$ 44,109.88	\$ 44,109.88
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 44,109.88	\$ 44,109.88

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 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.

A. Square Feet: 29,350

B. General Construction Type: Exterior BrickFrame SteelNumber 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: 295,295

2. Number of Years Over Which it is Being Amortized: 5

3. Current Period Amortization: 8,434

4. Dates Incurred: 2010-2012 Home Office Refinancing

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	391,343	2006	\$ 40,000	1
2					2
3	TOTALS	391,343		\$ 40,000	3

Facility Name & ID Number Collinsville Rehab & Hlth CC

0053470

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	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	100		2006	1962	\$ 1,635,299	\$	30	\$ 54,510	\$ 54,510	\$ 572,355	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Wheelchair Ramp			2007	2,530		15	169	169	1,605	9
10	Fountain			2007	1,269		15	85	85	807	10
11	Exit Signs			2007	612		7			612	11
12	Blinds			2007	4,886		10	489	489	4,645	12
13	Exit Signs			2008	690		15	46	46	391	13
14	Boiler			2009	6,500		7	927	927	6,500	14
15	Sprinkler Repair			2009	22,880		7	1,638	1,638	22,880	15
16	Boiler			2010	11,339		15	756	756	7,426	16
17	A/C Unit			2010	6,260		15	418	418	2,717	17
18	Roof Replacement			2010	69,464		25	2,778	2,778	18,057	18
19	Nurse Call Light System			2011	6,260		10	626	626	3,443	19
20	Ceiling Repair			2011	2,575		7	368	368	2,024	20
21	Roof Replacement-Completion of 2010 Work			2011	44,923		25	1,796	1,796	9,878	21
22	Roof Repairs			2012	3,047		7	436	436	1,962	22
23	Roof and Gutter Replacement			2012	64,790		25	2,592	2,592	11,664	23
24	Roof Repairs			2013	9,793		7	1,400	1,400	4,900	24
25	Condensing Unit			2014	4,500		7	643	643	1,608	25
26	Roof Replacement			2014	48,950		25	1,958	1,958	4,895	26
27	Flooring Replacement-Dining Room and Common Area			2015	15,946		15	1,064	1,064	1,596	27
28	Call Light Replacement System			2016	12,001		7	857	857	857	28
29	Fire Alarm Replacement System			2016	6,383		7	456	456	456	29
30	Water Heater			2016	4,054		7	290	290	290	30
31	Sod Installation			2016	12,903		10	645	645	645	31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number Collinsville Rehab & Hlth CC

0053470

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	Land Improvements Booked			253			(253)		63
64	Building Booked			65,634			(65,634)		64
65	Building Improvement Booked			17,145			(17,145)		65
66									66
67	2016-Home Office Allocation-Building Improvements		11,500			276	276		67
68	2016-Home Office Allocation-Land Improvements		1,058			69	69		68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,010,412	\$ 83,032		\$ 75,292	\$ (7,740)	\$ 682,213	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	\$247,044	\$5,057	\$15,351	\$10,294	5-10 yrs.	\$221,504	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Home Office Allocation			13,458	13,458			74
75	TOTALS	\$247,044	\$5,057	\$28,809	\$23,752		\$221,504	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$2,297,456	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$88,089	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$104,101	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$16,012	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$903,717	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	N/A				88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Nurse Station Remodeling	\$24,475	92
93			93
94			94
95		\$24,475	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? ☒ YES ☐ NO
16. Rental Amount for movable equipment: \$ 35,142 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	Facility	2015 Ford E150	\$ 570.75	\$ 6,849	17
18					18
19					19
20					20
21	TOTAL		\$ 570.75	\$ 6,849	21

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.	<u>/2017</u>	\$ _____
13.	<u>/2018</u>	\$ _____
14.	<u>/2019</u>	\$ _____

* 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.

Collinsville Rehab & Hlth CC
0053470

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	\$ 28,359
Dishwasher	702
Copier	4,959
Home Office Allocation	<u>1,122</u>
	<u><u>35,142</u></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)

		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)	\$			

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

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

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

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)										
		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		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	\$	7,764	\$ 116,455	\$	7,764	\$ 116,455	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,741	26,118		1,741	26,118	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		7,157	107,354	266	7,157	107,620	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				45,228		45,228	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			\$	16,662	\$ 249,927	\$ 45,494	16,662	\$ 295,421	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.

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (2,612,436)	\$ (2,612,436)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 154,041)	2,660,119	2,660,119	3
4	Supply Inventory (priced at Cost)	10,390	10,390	4
5	Short-Term Investments			5
6	Prepaid Insurance	28,739	28,739	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 86,812	\$ 86,812	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	43,799	40,000	13
14	Buildings, at Historical Cost	1,635,299	1,646,799	14
15	Leasehold Improvements, at Historical Cost	259,998	363,613	15
16	Equipment, at Historical Cost	251,929	247,044	16
17	Accumulated Depreciation (book methods)	(1,003,534)	(903,717)	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 CIP)	24,475	24,475	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,211,966	\$ 1,418,214	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,298,778	\$ 1,505,026	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 690,612	\$ 690,612	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	87,299	87,299	30
31	Accrued Taxes Payable (excluding real estate taxes)	462,708	462,708	31
32	Accrued Real Estate Taxes(Sch.IX-B)	78,514	78,514	32
33	Accrued Interest Payable	5,443	5,443	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	2,770	2,770	36
37	Accrued Management Fees	592,055	592,055	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,919,401	\$ 1,919,401	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,264,221	1,264,221	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Intercompany Loans	3,011	3,011	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,267,232	\$ 1,267,232	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,186,633	\$ 3,186,633	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,887,855)	\$ (1,681,607)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,298,778	\$ 1,505,026	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,601,093)	1
2	Restatements (describe):		2
3	Prior Period Adjustments Made After Cost Report Was Filed	(9,496)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,610,589)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	722,734	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)	\$ 722,734	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)	\$ (1,887,855)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Collinsville Rehab & Hlth CC

0053470

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	\$ 3,746,414	1
2	Discounts and Allowances for all Levels	(259,436)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,486,978	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	499,656	6
7	Oxygen	285	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 499,941	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	261	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	75,585	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	11,035	20
21	Other Medical Services	20,144	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 107,025	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	701	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 701	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Transportation Revenue</u>	1,250	28
28a	<u>Miscellaneous Revenue</u>	413	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,663	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,096,308	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	662,068	31
32	Health Care	1,576,979	32
33	General Administration	587,266	33
	B. Capital Expense		
34	Ownership	238,568	34
	C. Ancillary Expense		
35	Special Cost Centers	108,922	35
36	Provider Participation Fee	199,771	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,373,574	40
41	Income before Income Taxes (line 30 minus line 40)**	722,734	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 722,734	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 3,020,940	44
45	Private Pay - Net Inpatient Revenue	88,797	45
46	Medicare - Net Inpatient Revenue	377,200	46
47	Other-(specify) <u>Insurance Net Inpatient Revenue</u>	41	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,486,978	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	2,080	2,080	\$ 45,522	\$ 21.89	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,413	2,413	57,968	24.02	3
4	Licensed Practical Nurses	17,155	17,428	368,540	21.15	4
5	CNAs & Orderlies	40,460	41,082	486,142	11.83	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,943	1,959	22,059	11.26	9
10	Activity Assistants					10
11	Social Service Workers	2,080	2,080	37,595	18.07	11
12	Dietician					12
13	Food Service Supervisor	1,821	1,821	28,382	15.59	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,001	11,537	106,940	9.27	15
16	Dishwashers					16
17	Maintenance Workers	1,961	2,080	47,689	22.93	17
18	Housekeepers	14,747	14,902	139,977	9.39	18
19	Laundry	1,838	2,103	20,453	9.73	19
20	Administrator	2,080	2,080	58,000	27.88	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,537	1,675	24,434	14.59	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(specify)					32
33	Other(specify) See PG20A	8,844	8,904	166,987	18.75	33
34	TOTAL (lines 1 - 33)	109,960	112,144	\$ 1,610,688 *	\$ 14.36	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		\$		35
36	Medical Director	Monthly	14,400	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,141	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	4	231	L10A, C3	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)	4	\$ 20,772		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.

Collinsville Rehab & Hlth CC
0053470
Period Beginning 1/1/2016
Period End 12/31/2016

Schedule 20A

XVIII. Staffing and Salary Costs

		Reporting Period		
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries, Wages
		Average Hourly Wage		
Care Plan Coordinator		4,720	4,780	121,860
Restorative Aides		2,108	2,108	24,870
Transportation		2,016	2,016	20,257
TOTAL		8,844	8,904	166,987

Collinsville Rehab & Hlth CC
0053470
Period Beginning1/1/2016
Period End12/31/2016

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		27,517
Home Office Allocation		
Lucie, Scalf, and Bougher	Legal	61
Miscellaneous	Legal	24
Miller Hall and Triggs	Legal	105
Healthcare Resources International	Legal	525
Hunziker Law	Legal	125
Lexis Nexis	Legal	11
Illinois Secretary of State	Legal	76
Chicago Title Insurance	Legal	3,534
Bank Leumi	Legal	1,072
CliftonLarson Allen	Accountants	546
Ginoli & Co.	Accountants	4,664
Miscellaneous	Computer Services	69
Change Healthcare	Computer Services	10
PTC Select	Computer Services	6
Advanced Answers on Demand	Computer Services	4,797
Stratus Networks	Computer Services	488
Kemper Technology	Computer Services	322
AT&T	Computer Services	7
Ability Network	Computer Services	2,045
CIAN	Computer Services	244
Comcast	Computer Services	40
CCH	Computer Services	16
Charter Communications	Computer Services	47
Allscripts	Computer Services	713
ATS	Computer Services	322
Allpayer Exchange	Computer Services	16
Optimizer	Other Prof Fees	49
Ankura	Other Prof Fees	372
David Budde	Other Prof Fees	42
Bruner, Cooper, Zuck	Other Prof Fees	108
Marotta, Gund, Budd, Dzerda	Other Prof Fees	6,907
Professional Software and Services	Other Prof Fees	27
Hughes Valuation Services	Other Prof Fees	34
Alan Litwiller	Other Prof Fees	2

Total (agree to Schedule V, line 19, column 8)

54,943

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. IHCA-\$1,000

(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?

7 yrs.

(6)

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

\$

24,515

Line

10

(7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes

If NO, attach a complete explanation.

(8)

Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease.

N/A

(9)

Are you presently operating under a sublease agreement?

YES

X

NO

(10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

X

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$

199,771

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 benefit on Schedule V.

\$

0

Has any meal income been offset against related costs?

Yes

Indicate the amount.

\$

261

(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?

Yes

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$

1,250

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?

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?

Yes

Firm Name:

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.

No

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

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 Det	-77,707	equal to	-77,707	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expensi	103,279	equal to	103,279	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax	45,016	equal to	45,016	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exj	8,434	equal to	8,434	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Cost	104,101	equal to	104,101	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	41,991	equal to	41,991	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Traini	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 Service	250,193	equal to	250,193	0	O.K.	Pg16 Z12+Z14..	N/A,B	1-4,40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv.- S	45,494	equal to	45,494	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. Ge	662,068	equal to	662,068	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. He	1,576,979	equal to	1,576,979	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Ad	587,266	equal to	587,266	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ov	238,568	equal to	238,568	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Sp	108,922	equal to	108,922	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Pr	199,771	equal to	199,771	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	1,104,902	equal to	1,104,902	0	O.K.	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aidi	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed T	0	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	42,316	equal to	42,316	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Sei	37,595	equal to	37,595	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	135,322	equal to	135,322	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenar	47,689	equal to	47,689	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekee	139,977	equal to	139,977	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	20,453	equal to	20,453	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administr	58,000	equal to	58,000	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	24,434	equal to	24,434	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical D	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries A	1,610,688	equal to	1,552,688	58,000	FAILED	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consult	0	< or = to		#VALUE!	#VALUE!	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	14,400	< or = to	14,400	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & c	6,372	< or = to	7,156	-784	O.K.	Pg20 X14..X16+	B. & C.	17to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consult	0	< or = to	600	-600	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service C	0	< or = to		0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- A	58,000	equal to	58,000	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- A	274,300	equal to	274,300	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- F	27,517	equal to	27,517	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- E	236,505	equal to	236,505	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- S	7,457	equal to	7,457	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- S	58	equal to	58	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Parti	199,771	equal to	199,771	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Emp	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide train	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medical	1,804	equal to	1,976	-172	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for r	-13,597	equal to	-13,597	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4I	B.	14	8
Total loan balan	1,264,221	equal to	1,264,221	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27.	N/A	29+39-41	2
Real estate tax i	78,514	equal to	78,514	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	40,000	equal to	40,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	2,010,412	equal to	2,010,412	0	FAILED	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and i	247,044	equal to	247,044	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated de	903,717	equal to	903,717	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equ	-1,887,855	equal to	-1,887,855	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (los	722,734	equal to	722,734	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized de	0	equal to		0	O.K.	Pg22 F31-J31..J	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	1,298,778	equal to	1,298,778	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	Total
1. Dietary	135,322	18,471	0	153,793	0	153,793	5,351	159,144
2. Food Purchase	0	155,598	0	155,598	0	155,598	-164	155,434
3. Housekeeping	139,977	23,653	0	163,630	0	163,630	93	163,723
4. Laundry	20,453	12,703	0	33,156	0	33,156	0	33,156
5. Heat and Other Utilities	0	0	80,433	80,433	0	80,433	312	80,745
6. Maintenance	47,689	12,621	15,148	75,458	0	75,458	2,921	78,379
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	343,441	223,046	95,581	662,068	0	662,068	8,513	670,581
9. Medical Director	0	0	14,400	14,400	0	14,400	0	14,400
10. Nursing & Medical Records	1,104,902	119,705	7,156	1,231,763	0	1,231,763	-154	#####
10a. Therapy	0	266	249,927	250,193	0	250,193	0	250,193
11. Activities	42,316	112	600	43,028	0	43,028	-1,250	41,778
12. Social Services	37,595	0	0	37,595	0	37,595	0	37,595
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	1,184,813	120,083	272,083	1,576,979	0	1,576,979	-1,404	#####
17. Administrative	0	0	274,300	274,300	0	274,300	-216,300	58,000
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	27,517	27,517	0	27,517	27,426	54,943
20. Fees, Subscriptions & Promotion	0	0	6,887	6,887	0	6,887	570	7,457
21. Clerical & General Office	24,434	4,335	14,578	43,347	0	43,347	62,275	105,622
22. Employee Benefits & Payroll	0	0	201,627	201,627	0	201,627	34,878	236,505
23. Inservice Training & Education	0	0	-500	-500	0	-500	120	-380
24. Travel and Seminar	0	0	0	0	0	0	58	58
25. Other Admin. Staff Trans	0	0	4,257	4,257	0	4,257	4,907	9,164
26. Insurance-Prop.Liab.Malpractice	0	0	29,831	29,831	0	29,831	691	30,522
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	24,434	4,335	558,497	587,266	0	587,266	-85,375	501,891
29. Total General Administrative	1,552,688	347,464	926,161	2,826,313	0	2,826,313	-78,266	#####
30. Depreciation	0	0	88,089	88,089	0	88,089	16,012	104,101
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	8,434	8,434
32. Interest	0	0	64,912	64,912	0	64,912	38,367	103,279
33. Real Estate	0	0	44,698	44,698	0	44,698	318	45,016
34. Rent - Facility & Grounds	0	0	0	0	0	0	0	0
35. Rent - Equipment & Vehicles	0	0	40,869	40,869	0	40,869	1,122	41,991
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	238,568	238,568	0	238,568	64,253	302,821
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	45,228	0	45,228	0	45,228	0	45,228
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	199,771	199,771	0	199,771	0	199,771
43. Other (specify):*	0	144	63,550	63,694	0	63,694	-63,694	0
44. Total Special Cost Ce	0	45,372	263,321	308,693	0	308,693	-63,694	244,999
45. Grand Total	1,552,688	392,836	1,428,050	3,373,574	0	3,373,574	-77,707	#####

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	#####	-2,612,436
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	2,660,119	2,660,119
4. Supply Inventory	10,390	10,390
5. Short-Term Investments	0	0
6. Prepaid Insurance	28,739	28,739
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	0	0
10. Total current assets	86,812	86,812
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	43,799	40,000
14. Buildings, at Historical Cost	1,635,299	1,646,799
15. Leasehold Improvements, Historical Cost	259,998	363,613
16. Equipment, at Historical Cost	251,929	247,044
17. Accumulated Depreciation (book methods) #####		-903,717
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	24,475	24,475
23. other (specify):	0	0
24. Total Long-Term Assets	1,211,966	1,418,214
25. Total Assets	1,298,778	1,505,026
CURRENT LIABILITIES		
26. Accounts Payable	690,612	690,612
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	87,299	87,299
31. Accrued Taxes Payable	462,708	462,708
32. Accrued Real Estate Taxes	78,514	78,514
33. Accrued Interest Payable	5,443	5,443
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	2,770	2,770
37. Other Current Liabilities (specify):	592,055	592,055
38. Total Current Liabilities	1,919,401	1,919,401
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	1,264,221	1,264,221
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	3,011	3,011
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	1,267,232	1,267,232
46.Total Liabilities	3,186,633	3,186,633
47.Total Equity	#####	-1,681,607
48.Total Liabilities and Equity	1,298,778	1,505,026

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	3,746,414
2. Discounts and Allowances for all Levels	-259,436
Subtotal - Inpatient Care	3,486,978
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	499,656
7. Oxygen	285
Subtotal - Ancillary Revenue	499,941
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	261
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	75,585
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiology and X-Ray	11,035
21. Other Medical Services	20,144
22. Laundry	0
Subtotal - Other Operating Revenue	107,025
24. Contributions	0
25. Interest and Other Investments Income	701
Subtotal - Non-Operating Revenue	701
27. Other Revenue (specify):	1,250
28. Other Revenue (specify):	413
Subtotal - Other Revenue	1,663
30. Total Revenue	4,096,308
31. General Services	467,065
32. Health Care	1,115,340
33. General Administration	427,970
34. Ownership	185,084
35. Special Cost Centers	60,589
35. Provider Participation Fee	138,692
37. Other	0
40. Total Expenses	2,394,740
41. Income Before Income Taxes	1,701,568
42. Income Taxes	0
43. Net Income or Loss for the Year	1,701,568