

		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: 0053157

Facility Name: Enfield Rehab & Hlth Care Ct

Address: 408 North Wilson St Enfield 62835
Number City Zip Code

County: White

Telephone Number: (618) 963-2331 Fax # (618) 963-2083

HFS ID Number:

Date of Initial License for Current Owners: 10/01/2005

Type of Ownership:

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

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☒ 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

#	0053157	Report Period Beginning:	1/1/2016	Ending:	12/31/2016
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D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

N/A

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 23 and days of care provided

Medicare Intermediary National Government Services

MODIFIEDACCRUAL ☒

CASH*

CASH*	
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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.

	1 Level of Care	2	3	4	5	
		Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF		1,068	813	1,881	8
9	SNF/PED					9
10	ICF	8,562			8,562	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,562	1,068	813	10,443	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) **60.87%**

Facility Name & ID Number Enfield Rehab & Hlth Care Ct # 0053157 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	99,448	8,269	1,678	109,395		109,395	2,145	111,540			1
2	Food Purchase		67,312		67,312		67,312	(1,005)	66,307			2
3	Housekeeping	53,399	14,376		67,775		67,775	37	67,812			3
4	Laundry		2,964		2,964		2,964		2,964			4
5	Heat and Other Utilities			40,454	40,454		40,454	125	40,579			5
6	Maintenance	27,506	7,237	12,658	47,401		47,401	1,171	48,572			6
7	Other (specify):* Home Office Ben. Allocation											7
8	TOTAL General Services	180,353	100,158	54,790	335,301		335,301	2,473	337,774			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	483,801	94,309	3,876	581,986		581,986	(1,592)	580,394			10
10a	Therapy			57,686	57,686		57,686		57,686			10a
11	Activities	35,916			35,916		35,916	(3,455)	32,461			11
12	Social Services	27,850			27,850		27,850		27,850			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Office Ben. Allocation											15
16	TOTAL Health Care and Programs	547,567	94,309	67,562	709,438		709,438	(5,047)	704,391			16
	C. General Administration											
17	Administrative			157,800	157,800		157,800	(92,800)	65,000			17
18	Directors Fees											18
19	Professional Services			107,082	107,082		107,082	(86,117)	20,965			19
20	Dues, Fees, Subscriptions & Promotions			6,592	6,592		6,592	228	6,820			20
21	Clerical & General Office Expenses	5,821	923	8,228	14,972		14,972	24,977	39,949			21
22	Employee Benefits & Payroll Taxes			95,260	95,260		95,260	13,983	109,243			22
23	Inservice Training & Education							48	48			23
24	Travel and Seminar							23	23			24
25	Other Admin. Staff Transportation			4,351	4,351		4,351	1,967	6,318			25
26	Insurance-Prop.Liab.Malpractice			14,895	14,895		14,895	277	15,172			26
27	Other (specify):* Home Office Ben. Allocation											27
28	TOTAL General Administration	5,821	923	394,208	400,952		400,952	(137,414)	263,538			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	733,741	195,390	516,560	1,445,691		1,445,691	(139,988)	1,305,703			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			23,232	23,232		23,232	4,566	27,798			30
31	Amortization of Pre-Op. & Org.							14,748	14,748			31
32	Interest							22,262	22,262			32
33	Real Estate Taxes			7,783	7,783		7,783	127	7,910			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			23,274	23,274		23,274	450	23,724			35
36	Other (specify):*											36
37	TOTAL Ownership			54,289	54,289		54,289	42,153	96,442			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		27,025		27,025		27,025		27,025			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			84,365	84,365		84,365		84,365			42
43	Other (specify):*		184	13,918	14,102		14,102	(14,102)				43
44	TOTAL Special Cost Centers		27,209	98,283	125,492		125,492	(14,102)	111,390			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	733,741	222,599	669,132	1,625,472		1,625,472	(111,937)	1,513,535			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	(1,044)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,932)	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	(968)	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	(74)	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	(2,923)	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	(1,978)	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	(110,336)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (121,255)		\$	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)	9,318	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 9,318		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (111,937)		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	Offset Miscellaneous Nursing Supplies Revenue	\$ (1,656)	10	1
2	Resident Flowers	(97)	43	2
3	Offset Transportation Revenue	(3,455)	11	3
4	Disallow Special events	(426)	43	4
5	X-Rays Part A	(2,380)	43	5
6	Labs Part A	(2,292)	43	6
7	Offset Miscellaneous Office Supplies Revenue	(30)	21	7
8	Legal Settelement	(100,000)	19	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	(110,336)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Enfield Rehab & Hlth Care Ct# 0053157

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	2,145	0	0	0	0	0	0	0	0	0	2,145	1
2	Food Purchase	(1,044)	39	0	0	0	0	0	0	0	0	0	(1,005)	2
3	Housekeeping	0	37	0	0	0	0	0	0	0	0	0	37	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	125	0	0	0	0	0	0	0	0	0	125	5
6	Maintenance	0	1,171	0	0	0	0	0	0	0	0	0	1,171	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,044)	3,517	0	0	0	0	0	0	0	0	0	2,473	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	(1,656)	64	0	0	0	0	0	0	0	0	0	(1,592)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(3,455)	0	0	0	0	0	0	0	0	0	0	(3,455)	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	(5,111)	64	0	0	0	0	0	0	0	0	0	(5,047)	16
	C. General Administration													
17	Administrative	0	(92,800)	0	0	0	0	0	0	0	0	0	(92,800)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(100,000)	5,463	0	8,420	0	0	0	0	0	0	0	(86,117)	19
20	Fees, Subscriptions & Promotions	0	0	228	0	0	0	0	0	0	0	0	228	20
21	Clerical & General Office Expenses	(30)	0	25,007	0	0	0	0	0	0	0	0	24,977	21
22	Employee Benefits & Payroll Taxes	0	0	13,983	0	0	0	0	0	0	0	0	13,983	22
23	Inservice Training & Education	0	0	48	0	0	0	0	0	0	0	0	48	23
24	Travel and Seminar	0	0	23	0	0	0	0	0	0	0	0	23	24
25	Other Admin. Staff Transportation	0	0	1,967	0	0	0	0	0	0	0	0	1,967	25
26	Insurance-Prop.Liab.Malpractice	0	0	277	0	0	0	0	0	0	0	0	277	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(100,030)	(87,337)	41,533	8,420	0	0	0	0	0	0	0	(137,414)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(106,185)	(83,756)	41,533	8,420	0	0	0	0	0	0	0	(139,988)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Enfield Rehab & Hlth Care Ct # 0053157 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	(968)	0	5,534	0	0	0	0	0	0	0	0	4,566	30
31	Amortization of Pre-Op. & Org.	0	0	0	14,748	0	0	0	0	0	0	0	14,748	31
32	Interest	0	0	163	22,099	0	0	0	0	0	0	0	22,262	32
33	Real Estate Taxes	0	0	127	0	0	0	0	0	0	0	0	127	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	450	0	0	0	0	0	0	0	0	450	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(968)	0	6,274	36,847	0	0	0	0	0	0	0	42,153	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):*	(14,102)	0	0	0	0	0	0	0	0	0	0	(14,102)	43
44	TOTAL Special Cost Centers	(14,102)	0	0	0	0	0	0	0	0	0	0	(14,102)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(121,255)	(83,756)	47,807	45,267	0	0	0	0	0	0	0	(111,937)	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
<u>Mark B. Petersen</u>	<u>100</u>	<u>See PG6-Supp</u>		<u>See PG6-Supp</u>		

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	<u>Dietary</u>	\$	<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>\$ 2,145</u>	<u>\$ 2,145</u>	1
2	V	2	<u>Food</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>39</u>	<u>39</u>	2
3	V	3	<u>Housekeeping</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>37</u>	<u>37</u>	3
4	V	5	<u>Utilities</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>125</u>	<u>125</u>	4
5	V	6	<u>Maintenance</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>1,171</u>	<u>1,171</u>	5
6	V	7	<u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>0</u>		6
7	V	9	<u>Medical Director</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>0</u>		7
8	V	10	<u>Nursing and Medical Records</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>64</u>	<u>64</u>	8
9	V	10A	<u>Therapy</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>0</u>		9
10	V	15	<u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>0</u>		10
11	V	17	<u>Administrative</u>	<u>157,800</u>	<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>65,000</u>	<u>(92,800)</u>	11
12	V	19	<u>Professional Services</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>5,463</u>	<u>5,463</u>	12
13	V								13
14	Total			<u>\$ 157,800</u>			<u>\$ 74,044</u>	<u>\$ * (83,756)</u>	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%	\$ 228	\$ 228	15
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	25,007	25,007	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	13,983	13,983	17
18	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	48	48	18
19	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	23	23	19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	1,967	1,967	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	277	277	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%	5,534	5,534	23
24	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	163	163	24
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	127	127	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	450	450	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			\$			\$ 47,807	\$ * 47,807	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 Wellness, LLC	100.00%	\$ 0	\$	15
16	V	2	Food		Petersen Health Wellness, LLC	100.00%	0		16
17	V	3	Housekeeping		Petersen Health Wellness, LLC	100.00%	0		17
18	V	4	Laundry		Petersen Health Wellness, LLC	100.00%	0		18
19	V	5	Utilities		Petersen Health Wellness, LLC	100.00%	0		19
20	V	6	Maintenance		Petersen Health Wellness, LLC	100.00%	0		20
21	V	7	Mgmt. Allocation of Benefits		Petersen Health Wellness, LLC	100.00%	0		21
22	V	10	Nursing and Medical Records		Petersen Health Wellness, LLC	100.00%	0		22
23	V	15	Mgmt. Allocation of Benefits		Petersen Health Wellness, LLC	100.00%	0		23
24	V	17	Administrative		Petersen Health Wellness, LLC	100.00%	0		24
25	V	19	Professional Services		Petersen Health Wellness, LLC	100.00%	8,420	8,420	25
26	V	20	Dues, Fees, Subs & Promotions		Petersen Health Wellness, LLC	100.00%	0		26
27	V	21	Clerical and General Office		Petersen Health Wellness, LLC	100.00%	0		27
28	V	22	Employee Benefits & Payroll		Petersen Health Wellness, LLC	100.00%	0		28
29	V	23	Inservice Training & Education		Petersen Health Wellness, LLC	100.00%	0		29
30	V	24	Travel and Seminar		Petersen Health Wellness, LLC	100.00%	0		30
31	V	25	Other Admin. Staff Transport.		Petersen Health Wellness, LLC	100.00%	0		31
32	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Wellness, LLC	100.00%	0		32
33	V	30	Depreciation		Petersen Health Wellness, LLC	100.00%	0		33
34	V	31	Amortization		Petersen Health Wellness, LLC	100.00%	14,748	14,748	34
35	V	32	Interest		Petersen Health Wellness, LLC	100.00%	22,099	22,099	35
36	V	33	Real Estate Taxes		Petersen Health Wellness, LLC	100.00%	0		36
37	V	34	Rent-Facility and Grounds		Petersen Health Wellness, LLC	100.00%	0		37
38	V	35	Rent-Equipment & Vehicles		Petersen Health Wellness, LLC	100.00%	0		38
39	Total			\$			\$ 45,267	\$ * 45,267	39

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

Facility Name & ID Number

Enfield Rehab & Hlth Care Ct

0053157

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

Enfield Rehab & Hlth Care Ct

0053157

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

Enfield Rehab & Hlth Care Ct

0053157

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 Enfield Rehab & Hlth Care Ct # 0053157 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 Enfield Rehab & Hlth Care Ct# 0053157

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	10,443	\$ 2,145	1
2	2	Food	Resident Days	75	5,673	0	10,443	39	2
3	3	Housekeeping	Resident Days	75	5,456	2,897	10,443	37	3
4	5	Utilities	Resident Days	75	18,209	0	10,443	125	4
5	6	Maintenance	Resident Days	75	170,632	137,057	10,443	1,171	5
6	7	Mgmt. Allocation of Benefits	Resident Days	75	0	0	10,443	0	6
7	9	Medical Director	Resident Days	75	0	0	10,443	0	7
8	10	Nursing and Medical Records	Resident Days	75	9,261	1,782,521	10,443	64	8
9	10A	Therapy	Resident Days	75	0	0	10,443	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	75	0	0	10,443	0	10
11	17	Administrative	Resident Days	75	4,899,467	5,473,961	10,443	65,000	11
12	19	Professional Services	Resident Days	75	795,918	0	10,443	5,463	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	75	33,278	0	10,443	228	13
14	21	Clerical and General Office	Resident Days	75	3,643,535	3,756,135	10,443	25,007	14
15	22	Employee Benefits and Payroll Ta	Resident Days	75	2,037,314	0	10,443	13,983	15
16	23	Inservice Training & Education	Resident Days	75	6,986	0	10,443	48	16
17	24	Travel and Seminar	Resident Days	75	3,389	0	10,443	23	17
18	25	Other Admin. Staff Transport.	Resident Days	75	286,637	0	10,443	1,967	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	75	40,378	0	10,443	277	19
20	27	Mgmt. Allocation of Benefits	Resident Days	75	0	0	10,443	0	20
21	30	Depreciation	Resident Days	75	806,271	0	10,443	5,534	21
22	32	Interest	Resident Days	75	23,686	0	10,443	163	22
23	33	Real Estate Taxes	Resident Days	75	18,560	0	10,443	127	23
24	35	Rent-Equipment & Vehicles	Resident Days	75	65,550	0	10,443	450	24
25	TOTALS				\$ 13,182,740	\$ 11,510,481		\$ 121,851	25

Facility Name & ID Number Enfield Rehab & Hlth Care Ct# 0053157

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 Wellness, 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	94,948	7	\$	\$	10,443	\$	1
2	2	Food	Resident Days	94,948	7			10,443		2
3	3	Housekeeping	Resident Days	94,948	7			10,443		3
4	4	Laundry	Resident Days	94,948	7			10,443		4
5	5	Utilities	Resident Days	94,948	7			10,443		5
6	6	Maintenance	Resident Days	94,948	7			10,443		6
7	7	Mgmt. Allocation of Benefits	Resident Days	94,948	7			10,443		7
8	10	Nursing and Medical Records	Resident Days	94,948	7			10,443		8
9	15	Mgmt. Allocation of Benefits	Resident Days	94,948	7			10,443		9
10	17	Administrative	Resident Days	94,948	7			10,443		10
11	19	Professional Services	Resident Days	94,948	7	76,557		10,443	8,420	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	94,948	7			10,443		12
13	21	Clerical and General Office	Resident Days	94,948	7			10,443		13
14	22	Employee Benefits & Payroll	Resident Days	94,948	7			10,443		14
15	23	Inservice Training & Education	Resident Days	94,948	7			10,443		15
16	24	Travel and Seminar	Resident Days	94,948	7			10,443		16
17	25	Other Admin. Staff Transport.	Resident Days	94,948	7			10,443		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	94,948	7			10,443		18
19	30	Depreciation	Resident Days	94,948	7			10,443		19
20	31	Amortization	Resident Days	94,948	7	134,086		10,443	14,748	20
21	32	Interest	Resident Days	94,948	7	200,924		10,443	22,099	21
22	33	Real Estate Taxes	Resident Days	94,948	7			10,443		22
23	34	Rent-Facility and Grounds	Resident Days	94,948	7			10,443		23
24	35	Rent-Equipment & Vehicles	Resident Days	94,948	7			10,443		24
25	TOTALS					\$ 411,567	\$		\$ 45,267	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												\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$	\$			\$		9
	B. Non-Facility Related*												
10													10
11								Home Office Allocation-PHW			22,099		11
12								Home Office Allocation-PHCM			163		12
13													13
14	TOTAL Non-Facility Related						\$	\$			\$	22,262	14
15	TOTALS (line 9+line14)						\$	\$			\$	22,262	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.)

FACILITY NAME	Enfield Rehab & Hlth Care Ct	COUNTY	White
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CONTACT PERSON REGARDING THIS REPORT MIKE KOCHER

A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	

B. Real Estate Tax Cost Allocations

C. Tax Bills

Page 10A

A. Square Feet:

10,476

B. General Construction Type:

Exterior

Brick & Concrete

Frame

Wood

Number of Stories

1

C. Does the Operating Entity?

X

(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?

X

(a) Own the Equipment

(b) Rent equipment from a Related Organization.

X

(c) Rent equipment from Completely Unrelated Organization.

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

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

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

YES

X

NO

If so, please complete the following:

1. Total Amount Incurred:

99,556

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

20

3. Current Period Amortization:

14,748

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	\$ 15,750	1
2					2
3	TOTALS	75,359		\$ 15,750	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	49		2005	1972	\$ 290,250	\$	25	\$ 11,610	\$ 11,610	\$ 135,777
5										
6										
7										
8										
	Improvement Type**									
9	Door Alarm			2007	1,636		15	109	109	1,036
10	Air Compressor			2007	1,302		15	87	87	826
11	New Roof			2007	29,725		20	1,486	1,486	14,117
12	Awning			2008	2,569		20	128	128	1,088
13	Sprinkler System			2011	2,990		7	428	428	2,354
14	Sidewalk and Pavement Replacement			2013	35,360		25	1,414	1,414	4,949
15	Ceramic and vinyl tile installment-Main Hallways			2014	20,489		15	1,366	1,366	3,415
16	Water Heater			2014	14,671		7	2,096	2,096	5,240
17	Dry Valve Replacement			2016	9,790		7	699	699	699
18										
19										
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30	Land Improvements Booked					667			(667)	
31	Building Booked					11,253			(11,253)	
32	Building Improvement Booked					9,298			(9,298)	
33										
34	2016-Home Office Allocation-Building Improvements				4,611			111	111	
35	2016-Home Office Allocation-Land Improvements				424			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 Enfield Rehab & Hlth Care Ct

0053157

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)		\$ 413,817	\$ 21,218		\$ 19,562	\$ (1,656)	\$ 169,501	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	\$ 26,578	\$ 1,267	\$ 2,433	\$ 1,166	5-10 yrs.	\$ 21,703	71
72	Current Year Purchases	5,705	747	408	(339)	7 yrs.	408	72
73	Fully Depreciated Assets	58,420					58,420	73
74	Home Office Allocation			5,395	5,395			74
75	TOTALS	\$ 90,703	\$ 2,014	\$ 8,236	\$ 6,222		\$ 80,531	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				\$	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$	\$	\$	\$		\$

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)			\$	520,270
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	23,232
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	27,798
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	4,566
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	250,032

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?
- ☒ YES
☐ NO
16. Rental Amount for movable equipment: \$ 16,786
- 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			\$ 578.16	\$ 6,938	17
18	N/A				18
19					19
20					20
21	TOTAL		\$ 578.16	\$ 6,938	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.	/2017	\$
13.	/2018	\$
14.	/2019	\$

* 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.

Enfield Rehab & Hlth Care Ct
0053157

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	\$	12,542
Dishwasher		701
Copier		3,093
Home Office Allocation		450
		<u>16,786</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

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

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

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

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)										
		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		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	\$	1,725	\$ 25,874	\$	1,725	\$ 25,874	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		307	4,612		307	4,612	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		1,813	27,200		1,813	27,200	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				27,025		27,025	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	3,845	\$ 57,686	\$ 27,025	3,845	\$ 84,711	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	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (429,622)	\$ (429,622)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 21,907)	592,011	592,011	3
4	Supply Inventory (priced at Cost)	5,203	5,203	4
5	Short-Term Investments			5
6	Prepaid Insurance	14,331	14,331	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Employee Education Loans	500	500	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 182,423	\$ 182,423	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	25,750	15,750	13
14	Buildings, at Historical Cost	280,250	294,861	14
15	Leasehold Improvements, at Historical Cost	151,114	118,956	15
16	Equipment, at Historical Cost	90,703	90,703	16
17	Accumulated Depreciation (book methods)	(247,017)	(250,032)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 300,800	\$ 270,238	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 483,223	\$ 452,661	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 202,748	\$ 202,748	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	38,172	38,172	30
	Accrued Taxes Payable (excluding real estate taxes)	19,437	19,437	31
32	Accrued Real Estate Taxes(Sch.IX-B)	7,584	7,584	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	56,134	56,134	36
37	Accrued Management Fees	452,075	452,075	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 776,150	\$ 776,150	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Intercompany Loans	17	17	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 17	\$ 17	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 776,167	\$ 776,167	46
47	TOTAL EQUITY(page 18, line 24)	\$ (292,944)	\$ (323,506)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 483,223	\$ 452,661	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (255,977)	1
2	Restatements (describe):		2
3	Prior Period Adjustments Made After Cost Report Was Filed	(9,002)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (264,979)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(27,965)	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)	\$ (27,965)	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)	\$ (292,944)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Enfield Rehab & Hlth Care Ct

0053157

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	\$ 1,504,121	1
2	Discounts and Allowances for all Levels	(150,225)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,353,896	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	109,158	6
7	Oxygen	57	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 109,215	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	1,044	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	109,607	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	5,655	20
21	Other Medical Services	12,949	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 129,255	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>	3,455	28
28a	<u>Miscellaneous Revenue</u>	1,686	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 5,141	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,597,507	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	335,301	31
32	Health Care	709,438	32
33	General Administration	400,952	33
	B. Capital Expense		
34	Ownership	54,289	34
	C. Ancillary Expense		
35	Special Cost Centers	41,127	35
36	Provider Participation Fee	84,365	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,625,472	40
41	Income before Income Taxes (line 30 minus line 40)**	(27,965)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (27,965)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,077,337	44
45	Private Pay - Net Inpatient Revenue	180,952	45
46	Medicare - Net Inpatient Revenue	84,775	46
47	Other-(specify) <u>Insurance Net Inpatient Revenue</u>	10,832	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 1,353,896	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	2,349	2,365	\$ 53,208	\$ 22.50	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,352	1,390	27,466	19.76	3
4	Licensed Practical Nurses	11,514	11,863	182,371	15.37	4
5	CNAs & Orderlies	19,755	19,905	220,756	11.09	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,896	2,080	24,038	11.56	9
10	Activity Assistants	57	57	510	8.95	10
11	Social Service Workers	2,009	2,094	27,850	13.30	11
12	Dietician					12
13	Food Service Supervisor	1,877	2,078	29,243	14.07	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,161	6,761	70,205	10.38	15
16	Dishwashers					16
17	Maintenance Workers	1,800	1,895	27,506	14.52	17
18	Housekeepers	6,121	6,357	53,399	8.40	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	349	349	5,821	16.68	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) <u>Transportation</u>	1,040	1,040	11,368	10.93	33
34	TOTAL (lines 1 - 33)	56,280	58,234	\$ 733,741 *	\$ 12.60	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	28	\$ 1,678	L1,C3	35
36	Medical Director	Monthly	6,000	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,254	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	2	116	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)	30	\$ 10,048		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.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries	D. Employee Benefits and Payroll Taxes	F. Dues, Fees, Subscriptions and Promotions
NameFunction%Amount	DescriptionAmount	DescriptionAmount
Chastity HarrisAdministrator0\$65,000	Workers' Compensation Insurance\$17,351	IDPH License Fee\$3,980
	Unemployment Compensation Insurance21,550	Advertising: Employee Recruitment
	FICA Taxes53,314	Health Care Worker Background Check
	Employee Health Insurance2,705	(Indicate # of checks performed30)
	Employee Meals	Patient Background Checks7
	Illinois Municipal Retirement Fund (IMRF)*	Miscellaneous Licenses & Permits1,178
	Employee Relations340	Miscellaneous Dues & Subscriptions1,000
	Home Office Allocation13,983	Home Office Allocation228
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)\$65,000		
B. Administrative - Other		
DescriptionAmount		
Management Fees-See Page 6, Eliminated on P 3, C 7\$157,800		
TOTAL (agree to Schedule V, line 17, col. 3)\$157,800 (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/PayeeTypeAmount	DescriptionLine#Amount	DescriptionAmount
HAMILTON CO. COMMUNICATIONSComputer Services\$840		Out-of-State Travel\$
E-HEALTH DATA SOLUTIONSCOMPUTER SERVICES2,220		
HONKAMP & KRUEGERACCOUNTING SERVICES766	N/A	In-State Travel
SORLING NORTHRUPLEGAL SERVICES2,209		
FRONTIERCOMPUTER SERVICES732		
ABILITY NETWORKCOMPUTER SERVICES102		
JACKIE MEYERS AND WHAM & WHAMLEGAL SERVICES100,000		
WHITE CO CIRCUIT CLERKLEGAL SERVICES213		
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)\$107,082	TOTAL\$	Seminar Expense
		Home Office Allocation23
		Entertainment Expense()
		(agree to Sch. V, line 24, col. 8)
		TOTAL\$23

*** Attach copy of IMRF notifications**

****See instructions.**

Enfield Rehab & Hlth Care Ct
0053157
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)		107,082
Home Office Allocation		
Lucie, Scalf, and Bougher	Legal	24
Miscellaneous	Legal	10
Miller Hall and Triggs	Legal	42
Healthcare Resources International	Legal	210
Hunziker Law	Legal	50
Lexis Nexis	Legal	4
Gemino	Legal	3,793
Illinois Secretary of State	Legal	27
Peoria County Recorder	Legal	11
CliftonLarson Allen	Accountants	219
Ginoli & Co.	Accountants	2,224
Miscellaneous	Computer Services	28
Change Healthcare	Computer Services	4
PTC Select	Computer Services	2
Advanced Answers on Demand	Computer Services	1,923
Stratus Networks	Computer Services	196
Kemper Technology	Computer Services	129
AT&T	Computer Services	3
Ability Network	Computer Services	820
CIAN	Computer Services	98
Comcast	Computer Services	16
CCH	Computer Services	6
Charter Communications	Computer Services	19
Allscripts	Computer Services	286
ATS	Computer Services	129
Allpayer Exchange	Computer Services	7
Optimizer	Other Prof Fees	20
Ankura	Other Prof Fees	149
David Budde	Other Prof Fees	17
Bruner, Cooper, Zuck	Other Prof Fees	43
Marotta, Gund, Budd, Dzerda	Other Prof Fees	3,349
Professional Software and Services	Other Prof Fees	11
Hughes Valuation Services	Other Prof Fees	13
Alan Litwiller	Other Prof Fees	1

Total (agree to Schedule V, line 19, column 8)	<u><u>120,965</u></u>
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Enfield Rehab & Hlth Care Ct
0053157
Period Beginning
Period End

1/1/2016
12/31/2016

Schedule 21A

XIX. SUPPORT SCHEDULE
Legal Fees

Home Office Allocation-PHW & PHCM

Lucie, Scalf, and Bougher	Legal	24
Miscellaneous	Legal	10
Miller Hall and Triggs	Legal	42
Healthcare Resources International	Legal	210
Hunziker Law	Legal	50
Lexis Nexis	Legal	4
Gemino	Legal	3,793
Illinois Secretary of State	Legal	27
Peoria County Recorder	Legal	11

Direct Facility Invoices

Jackie Meyers, Wham & Wham Attorneys-Settlement	1/8/2016	100,000
Reclassing of Disallowed Settlement		(100,000)
Sorling Northrup-Jackie Meyers Appeal	1/8/2016	1,311
White County Circuit Clerk	2/2/2016	213
Sorling Northrup-Jackie Meyers Appeal	3/7/2016	472
Sorling Northrup-Jackie Meyers Appeal	2/8/2016	426

Total Legal Fees (agree to Schedule V, line 19, column 8)	<u>6,593</u>
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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. ICHA \$1000

(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.

\$ 7,919

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.

\$ 84,365

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.

\$ 1,044

(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.

\$ 3,455

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?

Yes

See page 39 of the instructions for details.

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

HFS 3745 (N-4-99)

IL478-2471

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 Detr	-111,937	equal to	-111,937	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expensi	22,262	equal to	22,262	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax	7,910	equal to	7,910	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exj	14,748	equal to	14,748	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Cost	27,798	equal to	27,798	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	23,724	equal to	23,724	0	FAILED	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	57,686	equal to	57,686	0	O.K.	Pg16 Z12+Z14..	N/A,B	1-4,40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv.- S	27,025	equal to	27,025	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. Ge	335,301	equal to	335,301	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. He	709,438	equal to	709,438	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Ad	400,952	equal to	400,952	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ov	54,289	equal to	54,289	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Sp	41,127	equal to	41,127	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Pri	84,365	equal to	84,365	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	483,801	equal to	483,801	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	35,916	equal to	35,916	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Sei	27,850	equal to	27,850	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	99,448	equal to	99,448	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenar	27,506	equal to	27,506	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekee	53,399	equal to	53,399	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	0	equal to		#VALUE!	#VALUE!	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administr	0	equal to	65,000	-65,000	FAILED	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	5,821	equal to	5,821	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	733,741	equal to	733,741	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consult	1,678	< or = to	1,678	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	6,000	< or = to	6,000	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & c	2,370	< or = to	3,876	-1,506	O.K.	Pg20 X14..X16+	B. & C.	17to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consult	0	< or = to		#VALUE!	#VALUE!	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	65,000	equal to	65,000	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- A	157,800	equal to	157,800	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- F	107,082	equal to	107,082	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- E	109,243	equal to	109,243	0	FAILED	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- S	6,820	equal to	6,820	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- S	23	equal to	23	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Parti	84,365	equal to	84,365	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	785	equal to	813	-28	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for r	9,318	equal to	9,318	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4I	B.	14	8
Total loan balan	0	equal to	0	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27.	N/A	29+39-41	2
Real estate tax i	7,584	equal to	7,584	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	15,750	equal to	15,750	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	413,817	equal to	413,817	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and i	90,703	equal to	90,703	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated de	250,032	equal to	250,032	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equ	-292,944	equal to	-292,944	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (los	-27,965	equal to	-27,965	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	483,223	equal to	483,223	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	99,448	8,269	1,678	109,395	0	109,395	2,145	111,540
2. Food Purchase	0	67,312	0	67,312	0	67,312	-1,005	66,307
3. Housekeeping	53,399	14,376	0	67,775	0	67,775	37	67,812
4. Laundry	0	2,964	0	2,964	0	2,964	0	2,964
5. Heat and Other Utilities	0	0	40,454	40,454	0	40,454	125	40,579
6. Maintenance	27,506	7,237	12,658	47,401	0	47,401	1,171	48,572
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	180,353	100,158	54,790	335,301	0	335,301	2,473	337,774
9. Medical Director	0	0	6,000	6,000	0	6,000	0	6,000
10. Nursing & Medical Records	483,801	94,309	3,876	581,986	0	581,986	-1,592	580,394
10a. Therapy	0	0	57,686	57,686	0	57,686	0	57,686
11. Activities	35,916	0	0	35,916	0	35,916	-3,455	32,461
12. Social Services	27,850	0	0	27,850	0	27,850	0	27,850
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	547,567	94,309	67,562	709,438	0	709,438	-5,047	704,391
17. Administrative	0	0	157,800	157,800	0	157,800	-92,800	65,000
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	107,082	107,082	0	107,082	-86,117	20,965
20. Fees, Subscriptions & Promotion	0	0	6,592	6,592	0	6,592	228	6,820
21. Clerical & General Office	5,821	923	8,228	14,972	0	14,972	24,977	39,949
22. Employee Benefits & Payroll	0	0	95,260	95,260	0	95,260	13,983	109,243
23. Inservice Training & Education	0	0	0	0	0	0	48	48
24. Travel and Seminar	0	0	0	0	0	0	23	23
25. Other Admin. Staff Trans	0	0	4,351	4,351	0	4,351	1,967	6,318
26. Insurance-Prop.Liab.Malpractice	0	0	14,895	14,895	0	14,895	277	15,172
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	5,821	923	394,208	400,952	0	400,952	-137,414	263,538
29. Total General Administrative	733,741	195,390	516,560	1,445,691	0	1,445,691	-139,988	#####
30. Depreciation	0	0	23,232	23,232	0	23,232	4,566	27,798
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	14,748	14,748
32. Interest	0	0	0	0	0	0	22,262	22,262
33. Real Estate	0	0	7,783	7,783	0	7,783	127	7,910
34. Rent - Facility & Grounds	0	0	0	0	0	0	0	0
35. Rent - Equipment & Vehicles	0	0	23,274	23,274	0	23,274	450	23,724
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	54,289	54,289	0	54,289	42,153	96,442
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	27,025	0	27,025	0	27,025	0	27,025
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	84,365	84,365	0	84,365	0	84,365
43. Other (specify):*	0	184	13,918	14,102	0	14,102	-14,102	0
44. Total Special Cost Ce	0	27,209	98,283	125,492	0	125,492	-14,102	111,390
45. Grand Total	733,741	222,599	669,132	1,625,472	0	1,625,472	-111,937	#####

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	-429,622	-429,622
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	592,011	592,011
4. Supply Inventory	5,203	5,203
5. Short-Term Investments	0	0
6. Prepaid Insurance	14,331	14,331
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	500	500
10. Total current assets	182,423	182,423
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	25,750	15,750
14. Buildings, at Historical Cost	280,250	294,861
15. Leasehold Improvements, Historical Cost	151,114	118,956
16. Equipment, at Historical Cost	90,703	90,703
17. Accumulated Depreciation (book methods)	-247,017	-250,032
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):	0	0
23. other (specify):	0	0
24. Total Long-Term Assets	300,800	270,238
25. Total Assets	483,223	452,661
CURRENT LIABILITIES		
26. Accounts Payable	202,748	202,748
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	38,172	38,172
31. Accrued Taxes Payable	19,437	19,437
32. Accrued Real Estate Taxes	7,584	7,584
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	56,134	56,134
37. Other Current Liabilities (specify):	452,075	452,075
38. Total Current Liabilities	776,150	776,150
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	0
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	17	17
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	17	17
46.Total Liabilities	776,167	776,167
47.Total Equity	-292,944	-323,506
48.Total Liabilities and Equity	483,223	452,661

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	1,504,121
2. Discounts and Allowances for all Levels	-150,225
Subtotal - Inpatient Care	1,353,896
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	109,158
7. Oxygen	57
Subtotal - Anciliary Revenue	109,215
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	1,044
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	109,607
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiology and X-Ray	5,655
21. Other Medical Services	12,949
22. Laundry	0
Subtotal - Other Operating Revenue	129,255
24. Contributions	0
25. Interest and Other Investments Income	0
Subtotal - Non-Operating Revenue	-
27. Other Revenue (specify):	3,455
28. Other Revenue (specify):	1,686
Subtotal - Other Revenue	5,141
30. Total Revenue	1,597,507
31. General Services	312,887
32. Health Care	585,581
33. General Administration	281,957
34. Ownership	51,973
35. Special Cost Centers	59,734
35. Provider Participation Fee	76,972
37. Other	0
40. Total Expenses	1,369,104
41. Income Before Income Taxes	228,403
42. Income Taxes	0
43. Net Income or Loss for the Year	228,403