

		FOR BHF USE					

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

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

I. IDPH License ID Number: <u>0053132</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Kewanee Care Home</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2016</u> to <u>12/31/2016</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>144 Junior Avenue</u> <u>Kewanee</u> <u>61443</u>																									
Number City Zip Code																									
County: <u>Henry</u>																									
Telephone Number: <u>(309) 853-4429</u> Fax # <u>(309) 853-4400</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td>(Type or Print Name) <u>Mark B. Petersen</u></td></tr><tr><td>(Title) <u>Chief Executive Officer</u></td></tr><tr><td rowspan="5">Paid Preparer</td><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) _____</td></tr><tr><td>(Telephone) <u>()</u> Fax # <u>()</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) <u>Mark B. Petersen</u>	(Title) <u>Chief Executive Officer</u>	Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) _____	(Telephone) <u>()</u> Fax # <u>()</u>											
Officer or Administrator of Provider	(Signed) _____																								
	(Date) _____																								
	(Type or Print Name) <u>Mark B. Petersen</u>																								
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Paid Preparer	(Signed) _____																								
	(Date) _____																								
	(Print Name and Title) _____																								
	(Firm Name & Address) _____																								
	(Telephone) <u>()</u> Fax # <u>()</u>																								
Date of Initial License for Current Owners: <u>06/01/76</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td>_____</td></tr><tr><td></td><td>☐ Other _____</td><td>_____</td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☒ Limited Liability Co.	_____		☐ Trust	_____		☐ Other _____	_____
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	☒ Limited Liability Co.	_____																							
	☐ Trust	_____																							
	☐ Other _____	_____																							
In the event there are further questions about this report, please contact:		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																							
Name: <u>Mike Kocher</u> Telephone Number: <u>(309) 689-5850</u>																									
Email Address: _____																									

Facility Name & ID Number Kewanee Care Home

0053132 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>27</u>	Skilled (SNF)	<u>27</u>	<u>9,855</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>57</u>	Intermediate (ICF)	<u>57</u>	<u>20,805</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>84</u>	TOTALS	<u>84</u>	<u>30,660</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF		<u>5,808</u>	<u>3,145</u>	<u>8,953</u>	8
9	SNF/PED					9
10	ICF	<u>14,757</u>			<u>14,757</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>14,757</u>	<u>5,808</u>	<u>3,145</u>	<u>23,710</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.33%

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 6/1/1976

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

YES

☒

Date

NO

☐

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

YES

☒

NO

☐

If YES, enter number

of beds certified

27

and days of care provided

2,621

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL

☒

MODIFIED

CASH*

☐

CASH*

☐

Is your fiscal year identical to your tax year?

YES

☒

NO

☐

Tax Year: 12/31/2016

Fiscal Year: 12/31/2016

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

Facility Name & ID Number Kewanee Care Home # 0053132 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	145,088	14,160		159,248		159,248	4,870	164,118			1
2	Food Purchase		150,512		150,512		150,512	(4,841)	145,671			2
3	Housekeeping	98,955	22,045		121,000		121,000	85	121,085			3
4	Laundry	49,698	17,425		67,123		67,123		67,123			4
5	Heat and Other Utilities			46,287	46,287		46,287	284	46,571			5
6	Maintenance	34,979	18,494	54,724	108,197		108,197	10,500	118,697			6
7	Other (specify):* <u>Home Office Ben. Allocation</u>											7
8	TOTAL General Services	328,720	222,636	101,011	652,367		652,367	10,898	663,265			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,056,835	96,763	7,836	1,161,434		1,161,434	(495)	1,160,939			10
10a	Therapy			352,730	352,730		352,730		352,730			10a
11	Activities	55,010			55,010		55,010	(10,946)	44,064			11
12	Social Services	19,370			19,370		19,370		19,370			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	1,131,215	96,763	372,566	1,600,544		1,600,544	(11,441)	1,589,103			16
	C. General Administration											
17	Administrative			302,200	302,200		302,200	(241,395)	60,805			17
18	Directors Fees											18
19	Professional Services			16,418	16,418		16,418	30,632	47,050			19
20	Dues, Fees, Subscriptions & Promotions			9,444	9,444		9,444	244	9,688			20
21	Clerical & General Office Expenses	31,221	7,063	18,997	57,281		57,281	59,114	116,395			21
22	Employee Benefits & Payroll Taxes			191,909	191,909		191,909	31,747	223,656			22
23	Inservice Training & Education			728	728		728	109	837			23
24	Travel and Seminar							53	53			24
25	Other Admin. Staff Transportation			13,014	13,014		13,014	4,467	17,481			25
26	Insurance-Prop.Liab.Malpractice			20,914	20,914		20,914	29,123	50,037			26
27	Other (specify):* <u>Home Office Ben. Allocation</u>											27
28	TOTAL General Administration	31,221	7,063	573,624	611,908		611,908	(85,906)	526,002			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,491,156	326,462	1,047,201	2,864,819		2,864,819	(86,449)	2,778,370			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			2,072	2,072		2,072	79,616	81,688			30
31	Amortization of Pre-Op. & Org.							9,145	9,145			31
32	Interest							150,263	150,263			32
33	Real Estate Taxes							58,003	58,003			33
34	Rent-Facility & Grounds			373,483	373,483		373,483	(373,483)				34
35	Rent-Equipment & Vehicles			32,229	32,229		32,229	1,021	33,250			35
36	Other (specify):*											36
37	TOTAL Ownership			407,784	407,784		407,784	(75,435)	332,349			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		90,074		90,074		90,074		90,074			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			171,097	171,097		171,097		171,097			42
43	Other (specify):*	24,639	1,350	34,369	60,358		60,358	(60,358)				43
44	TOTAL Special Cost Centers	24,639	91,424	205,466	321,529		321,529	(60,358)	261,171			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,515,795	417,886	1,660,451	3,594,132		3,594,132	(222,242)	3,371,890			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	(4,929)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	236	30		9
10	Interest and Other Investment Income	(62)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(327)	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	(22,152)	43		18
19	Entertainment				19
20	Contributions	(141)	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				24
25	Fund Raising, Advertising and Promotional	(2,500)	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	(47,253)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (77,128)		\$	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)	(145,114)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (145,114)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (222,242)		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	\$ (2,810)	43	1
2	X-Rays-Part A	(9,779)	43	2
3	Offset of Transportation Income	(10,946)	11	3
4	Offset Chamber of Commerce Dues	(275)	20	4
5	Offset of Office Supplies Income	(155)	21	5
6	Disallowed Special Events	1,990	43	6
7	Disallowed Marketing Expense	(24,639)	43	7
8	Offset of Nursing Supplies Income	(639)	21	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	(47,253)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Kewanee Care Home# 0053132

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	4,870	0	0	0	0	0	0	0	0	0	4,870	1
2	Food Purchase	(4,929)	88	0	0	0	0	0	0	0	0	0	(4,841)	2
3	Housekeeping	0	85	0	0	0	0	0	0	0	0	0	85	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	284	0	0	0	0	0	0	0	0	0	284	5
6	Maintenance	0	2,659	0	0	7,841	0	0	0	0	0	0	10,500	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(4,929)	7,986	0	0	7,841	0	0	0	0	0	0	10,898	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	144	0	0	0	0	0	0	0	0	0	144	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(10,946)	0	0	0	0	0	0	0	0	0	0	(10,946)	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	(10,946)	144	0	0	0	0	0	0	0	0	0	(10,802)	16
	C. General Administration													
17	Administrative	0	(241,395)	0	0	0	0	0	0	0	0	0	(241,395)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	12,403	0	11,389	6,840	0	0	0	0	0	0	30,632	19
20	Fees, Subscriptions & Promotions	(275)	0	519	0	0	0	0	0	0	0	0	244	20
21	Clerical & General Office Expenses	(794)	0	56,777	0	2,492	0	0	0	0	0	0	58,475	21
22	Employee Benefits & Payroll Taxes	0	0	31,747	0	0	0	0	0	0	0	0	31,747	22
23	Inservice Training & Education	0	0	109	0	0	0	0	0	0	0	0	109	23
24	Travel and Seminar	0	0	53	0	0	0	0	0	0	0	0	53	24
25	Other Admin. Staff Transportation	0	0	4,467	0	0	0	0	0	0	0	0	4,467	25
26	Insurance-Prop.Liab.Malpractice	0	0	629	0	28,494	0	0	0	0	0	0	29,123	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(1,069)	(228,992)	94,301	11,389	37,826	0	0	0	0	0	0	(86,545)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(16,944)	(220,862)	94,301	11,389	45,667	0	0	0	0	0	0	(86,449)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Kewanee Care Home # 0053132 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	236	0	12,564	0	66,816	0	0	0	0	0	0	79,616	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	9,145	0	0	0	0	0	0	9,145	31
32	Interest	(62)	0	369	8,604	141,352	0	0	0	0	0	0	150,263	32
33	Real Estate Taxes	0	0	289	0	57,714	0	0	0	0	0	0	58,003	33
34	Rent-Facility & Grounds	0	0	0	0	(373,483)	0	0	0	0	0	0	(373,483)	34
35	Rent-Equipment & Vehicles	0	0	1,021	0	0	0	0	0	0	0	0	1,021	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	174	0	14,243	8,604	(98,456)	0	0	0	0	0	0	(75,435)	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):*	(60,358)	0	0	0	0	0	0	0	0	0	0	(60,358)	43
44	TOTAL Special Cost Centers	(60,358)	0	0	0	0	0	0	0	0	0	0	(60,358)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(77,128)	(220,862)	108,544	19,993	(52,789)	0	0	0	0	0	0	(222,242)	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%	\$ 4,870	\$ 4,870	1
2	V	2	Food		Petersen Health Care Management, Inc.	100.00%	88	88	2
3	V	3	Housekeeping		Petersen Health Care Management, Inc.	100.00%	85	85	3
4	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	284	284	4
5	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	2,659	2,659	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%	144	144	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	302,200	Petersen Health Care Management, Inc.	100.00%	60,805	(241,395)	11
12	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	12,403	12,403	12
13	V								13
14	Total			\$ 302,200			\$ 81,338	\$ * (220,862)	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%	\$ 519	\$ 519	15
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	56,777	56,777	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	31,747	31,747	17
18	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	109	109	18
19	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	53	53	19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	4,467	4,467	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	629	629	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%	12,564	12,564	23
24	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	369	369	24
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	289	289	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	1,021	1,021	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			\$			\$ 108,544	\$ * 108,544	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 Junction, LLC	100.00%	\$ 0	\$	15
16	V	2	Food		Petersen Health Junction, LLC	100.00%	0		16
17	V	3	Housekeeping		Petersen Health Junction, LLC	100.00%	0		17
18	V	4	Laundry		Petersen Health Junction, LLC	100.00%	0		18
19	V	5	Utilities		Petersen Health Junction, LLC	100.00%	0		19
20	V	6	Maintenance		Petersen Health Junction, LLC	100.00%	0		20
21	V	7	Mgmt. Allocation of Benefits		Petersen Health Junction, LLC	100.00%	0		21
22	V	10	Nursing and Medical Records		Petersen Health Junction, LLC	100.00%	0		22
23	V	15	Mgmt. Allocation of Benefits		Petersen Health Junction, LLC	100.00%	0		23
24	V	17	Administrative		Petersen Health Junction, LLC	100.00%	0		24
25	V	19	Professional Services		Petersen Health Junction, LLC	100.00%	11,389	11,389	25
26	V	20	Dues, Fees, Subs & Promotions		Petersen Health Junction, LLC	100.00%	0		26
27	V	21	Clerical and General Office		Petersen Health Junction, LLC	100.00%	0		27
28	V	22	Employee Benefits & Payroll		Petersen Health Junction, LLC	100.00%	0		28
29	V	23	Inservice Training & Education		Petersen Health Junction, LLC	100.00%	0		29
30	V	24	Travel and Seminar		Petersen Health Junction, LLC	100.00%	0		30
31	V	25	Other Admin. Staff Transport.		Petersen Health Junction, LLC	100.00%	0		31
32	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Junction, LLC	100.00%	0		32
33	V	30	Depreciation		Petersen Health Junction, LLC	100.00%	0		33
34	V	31	Amortization		Petersen Health Junction, LLC	100.00%	0		34
35	V	32	Interest		Petersen Health Junction, LLC	100.00%	8,604	8,604	35
36	V	33	Real Estate Taxes		Petersen Health Junction, LLC	100.00%	0		36
37	V	34	Rent-Facility and Grounds		Petersen Health Junction, LLC	100.00%	0		37
38	V	35	Rent-Equipment & Vehicles		Petersen Health Junction, LLC	100.00%	0		38
39	Total			\$			\$ 19,993	\$ * 19,993	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	19	Professional Fees	\$	Kewanee Land	100.00%	\$ 6,840	\$ 6,840	15
16	V	26	Property Insurance		Kewanee Land	100.00%	4,397	4,397	16
17	V	26	Mortgage Insurance		Kewanee Land	100.00%	24,097	24,097	17
18	V	30	Depreciation		Kewanee Land	100.00%	66,816	66,816	18
19	V	31	Amortization		Kewanee Land	100.00%	9,145	9,145	19
20	V	32	Interest	1,387	Kewanee Land	100.00%	142,739	141,352	20
21	V	33	Real Estate Taxes		Kewanee Land	100.00%	57,714	57,714	21
22	V	34	Rent-Facility & Grounds	373,483	Kewanee Land	100.00%		(373,483)	22
23	V	6	Maintenance		Kewanee Land	100.00%	7,841	7,841	23
24	V	21	Minor Equipment		Kewanee Land	100.00%	2,492	2,492	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 374,870			\$ 322,081	\$ * (52,789)	39

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

Facility Name & ID Number

Kewanee Care Home

0053132

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

Kewanee Care Home

0053132

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

Kewanee Care Home

0053132

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

Facility Name & ID Number

Kewanee Care Home

0053132

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			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 Kewanee Care Home # 0053132 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 Kewanee Care Home# 0053132

Report Period Beginning:

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Petersen Health Care Management, Inc.

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309) 691-8113

Fax Number

(309) 691-8622

1	2	3	4	5	6	7	8	9	
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line	Item	(i.e., Days, Direct Cost, Square Feet)	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference				Allocated Among	Allocated	in Column 6			
1	1	Dietary	Resident Days	75	\$ 312,540	\$ 357,910	23,710	\$ 4,870	1
2	2	Food	Resident Days	75	5,673	0	23,710	88	2
3	3	Housekeeping	Resident Days	75	5,456	2,897	23,710	85	3
4	5	Utilities	Resident Days	75	18,209	0	23,710	284	4
5	6	Maintenance	Resident Days	75	170,632	137,057	23,710	2,659	5
6	7	Mgmt. Allocation of Benefits	Resident Days	75	0	0	23,710	0	6
7	9	Medical Director	Resident Days	75	0	0	23,710	0	7
8	10	Nursing and Medical Records	Resident Days	75	9,261	1,782,521	23,710	144	8
9	10A	Therapy	Resident Days	75	0	0	23,710	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	75	0	0	23,710	0	10
11	17	Administrative	Resident Days	75	4,899,467	5,473,961	23,710	60,805	11
12	19	Professional Services	Resident Days	75	795,918	0	23,710	12,403	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	75	33,278	0	23,710	519	13
14	21	Clerical and General Office	Resident Days	75	3,643,535	3,756,135	23,710	56,777	14
15	22	Employee Benefits and Payroll Ta	Resident Days	75	2,037,314	0	23,710	31,747	15
16	23	Inservice Training & Education	Resident Days	75	6,986	0	23,710	109	16
17	24	Travel and Seminar	Resident Days	75	3,389	0	23,710	53	17
18	25	Other Admin. Staff Transport.	Resident Days	75	286,637	0	23,710	4,467	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	75	40,378	0	23,710	629	19
20	27	Mgmt. Allocation of Benefits	Resident Days	75	0	0	23,710	0	20
21	30	Depreciation	Resident Days	75	806,271	0	23,710	12,564	21
22	32	Interest	Resident Days	75	23,686	0	23,710	369	22
23	33	Real Estate Taxes	Resident Days	75	18,560	0	23,710	289	23
24	35	Rent-Equipment & Vehicles	Resident Days	75	65,550	0	23,710	1,021	24
25	TOTALS				\$ 13,182,740	\$ 11,510,481		\$ 189,882	25

Facility Name & ID Number Kewanee Care Home# 0053132

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 Junction, 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	57,459	2	\$	\$	23,710	\$	1
2	2	Food	Resident Days	57,459	2			23,710		2
3	3	Housekeeping	Resident Days	57,459	2			23,710		3
4	4	Laundry	Resident Days	57,459	2			23,710		4
5	5	Utilities	Resident Days	57,459	2			23,710		5
6	6	Maintenance	Resident Days	57,459	2			23,710		6
7	7	Mgmt. Allocation of Benefits	Resident Days	57,459	2			23,710		7
8	10	Nursing and Medical Records	Resident Days	57,459	2			23,710		8
9	15	Mgmt. Allocation of Benefits	Resident Days	57,459	2			23,710		9
10	17	Administrative	Resident Days	57,459	2			23,710		10
11	19	Professional Services	Resident Days	57,459	2	28,005		23,710	11,389	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	57,459	2			23,710		12
13	21	Clerical and General Office	Resident Days	57,459	2			23,710		13
14	22	Employee Benefits & Payroll	Resident Days	57,459	2			23,710		14
15	23	Inservice Training & Education	Resident Days	57,459	2			23,710		15
16	24	Travel and Seminar	Resident Days	57,459	2			23,710		16
17	25	Other Admin. Staff Transport.	Resident Days	57,459	2			23,710		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	57,459	2			23,710		18
19	30	Depreciation	Resident Days	57,459	2			23,710		19
20	31	Amortization	Resident Days	57,459	2			23,710		20
21	32	Interest	Resident Days	57,459	2	21,156		23,710	8,604	21
22	33	Real Estate Taxes	Resident Days	57,459	2			23,710		22
23	34	Rent-Facility and Grounds	Resident Days	57,459	2			23,710		23
24	35	Rent-Equipment & Vehicles	Resident Days	57,459	2			23,710		24
25	TOTALS					\$ 49,161	\$		\$ 19,993	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Capital Finance Group		X	Mortgage	Varies	1/1/14	\$ 3,870,400	\$ 3,662,160	12/31/39	Varies	\$ 142,739	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 3,870,400	\$ 3,662,160			\$ 142,739	9	
	B. Non-Facility Related*												
10								Interest Income Offset			(1,449)	10	
11								Home Office Allocation-PHCM			369	11	
12								Home Office Allocation-PHJ			8,604	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ 7,524	14	
15	TOTALS (line 9+line14)						\$ 3,870,400	\$ 3,662,160			\$ 150,263	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.)

B. Real Estate Taxes

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 Kewanee Care Home COUNTY Henry

FACILITY IDPH LICENSE NUMBER 0053132

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) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 25-05-281-017	901 W. Mill St.	\$ 121.00	\$ 121.00
2. 25-04-151-009	144 Junior Ave.	\$ 55,389.04	\$ 55,389.04
3. 25-04-152-001	821 Dewey Ave.	\$ 91.82	\$ 91.82
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 55,601.86	\$ 55,601.86

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:

12,548

B. General Construction Type:

Exterior

Brick

Frame

Steel

Number 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:

228,631

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

25

3. Current Period Amortization:

9,145

4. Dates Incurred:

2013-2014

Nature of Costs:

Loan Costs 2010-2013

(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	42,000	1976	\$ 25,000	1
2	Facility	11,250	1992	25,621	2
3	TOTALS	53,250		\$ 50,621	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			1976		\$ 381,128	\$	30	\$		\$ 381,128	4
5			1998	1998	753,696		40	18,842	18,842	350,631	5
6			2002	2002	661,677		40	16,542	16,542	209,682	6
7											7
8											8
	Improvement Type**										
9	1984-1995 Fully Depreciated Assets				132,955					132,955	9
10	Tile Flooring			1996	1,083		20	12	12	1,083	10
11	Curtains Custom			1996	1,275		20	64	64	1,259	11
12	Emergency Light			1996	304		20	9	9	304	12
13	Fire Alarm			1996	2,099		20	34	34	2,099	13
14	Tile Flooring			1996	1,287		20	34	34	1,287	14
15	Boiler			1996	2,996		20	150	150	2,952	15
16	Water Heater Repair			1996	1,010		20			1,010	16
17	Ceiling Repairs			1996	2,117		20	6	6	2,117	17
18	Piping Repairs			1996	855		20			855	18
19	Fire Alarm			1996	1,331		20	47	47	1,331	19
20	Fire System			1996	1,564		20	49	49	1,564	20
21	Landscaping			1996	9,815		20	200	200	9,815	21
22	Landscaping			1996	1,986		20	72	72	1,986	22
23	Chrome Door Knob			1996	72		20			72	23
24	Emergency Light			1996	182		20	2	2	182	24
25	Painting			1996	672		20			672	25
26	Floor Tile			1997	8,472		20	424	424	8,409	26
27	Storage Shed			1997	\$ 10,177	\$	20	\$ 509	509	9,883	27
28	Windows			1997	5,136		20	257	257	5,012	28
29	Ceiling Repairs			1997	8,291		20	415	415	8,023	29
30	Landscaping			1997	8,085		20	404	404	7,777	30
31	Landscaping			1997	1,298		20	65	65	1,251	31
32	Whirlpool			1997	9,343		20	467	467	8,912	32
33	Boiler			1997	3,000		20	150	150	2,875	33
34	Wing Additions			1997	3,700		20	25	25	3,050	34
35	Attic Piping			1997	3,318		20	166	166	3,223	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 Kewanee Care Home

0053132

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	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 Compressor	1997	809		20	40	\$ 40	\$ 763	37
38 Fire Alarm	1997	2,338		20	117	117	2,302	38
39 Code Alert Receiver	1997	1,863		20	93	93	1,829	39
40 New sign	1998	7,304		20			7,304	40
41 Landscaping	1998	21,500		20	1,075	1,075	20,067	41
42 Duct Work-New Wing	1999	1,494		20	75	75	1,312	42
43 Tiling	1999	914		20	46	46	805	43
44 Water Heater	1999	2,835		20	142	142	2,485	44
45 Water Heater	1999	3,766		20	188	188	3,290	45
46 Cubicle Partitions	1999	701		20	35	35	612	46
47 Beauty Salon	2000	943		20	47	47	776	47
48 Tile Flooring	2000	10,219		20	511	511	8,489	48
49 Lot/House Razed	2000	5,061		20			5,061	49
50 Concrete	2001	900		15			900	50
51 Landscaping	2001	1,045		15			1,045	51
52 Lighting	2001	3,438		39	88	88	1,408	52
53 Blinds/Curtains	2001	9,500		7			9,500	53
54 Landscaping	2002	24,614		15	1,641	1,641	23,794	54
55 Landscaping	2002	4,075		15	272	272	3,944	55
56 Architectural	2002	15,602		20	780	780	15,172	56
57 Carpeting	2002	2,551		20	128	128	1,856	57
58 Fire System	2002	4,677		20	234	234	3,393	58
59 Landscaping	2003	4,899		15	327	327	4,414	59
60 Simplex Time Clock	2004	3,198		10			3,198	60
61 Air Conditioner	2004	2,700		10			2,700	61
62 Side walks	2005	2,065		15	138	138	1,656	62
63 Floor covering	2005	13,891		7			13,891	63
64 Flooring	2006	28,527		25	1,141	1,141	11,981	64
65 Driveway	2007	7,101		15	473	473	4,494	65
66 Boiler	2007	2,895		10	290	290	2,755	66
67 Sprinkler System Repair	2008	2,583		5			2,583	67
68 Painting of Dining Room	2008	2,825		39	72	72	612	68
69								69
70 TOTAL (lines 4 thru 69)		\$ 2,215,757	\$		\$ 46,898	\$ 46,898	\$ 1,325,790	70

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

Facility Name & ID Number Kewanee Care Home

0053132

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,215,757	\$		\$ 46,898	\$ 46,898	\$ 1,325,790	1
2	<u>Sprinkler System Repair</u>	2008	2,689		5			2,689	2
3	<u>Fencing</u>	2009	3,400		15	226	226	1,695	3
4	<u>Boiler</u>	2010	2,900		20	146	146	949	4
5	<u>Compressor Repair</u>	2010	2,639		7	376	376	1,974	5
6	<u>Dry Pendent Head Replacement</u>	2011	8,857		7	1,266	1,266	6,963	6
7	<u>Compressor</u>	2012	2,685		7	384	384	1,728	7
8	<u>Air Conditioner-Central System</u>	2012	2,978		15	198	198	891	8
9	<u>Furnace, Air Conditoner, and Boiler</u>	2012	17,929		15	1,195	1,195	7,214	9
10	<u>A/C Repair</u>	2013	3,455		7	494	494	1,729	10
11	<u>Water Pipe Repair</u>	2013	5,861		7	838	838	2,933	11
12	<u>Smoke and Heat</u>	2014	2,742		7	392	392	980	12
13	<u>Alarm System</u>	2014	4,344		7	621	621	1,553	13
14	<u>Water Line Repair</u>	2014	2,712		7	387	387	968	14
15	<u>Water Pipe Repair</u>	2014	2,550		7	364	364	910	15
16	<u>Water Line Repair</u>	2014	3,860		7	551	551	1,378	16
17	<u>Boiler</u>	2014	3,552		15	237	237	593	17
18	<u>Dry Pendent Head Replacement</u>	2015	3,973		7	568	568	852	18
19	<u>Roof Replacement</u>	2015	110,000		25	4,450	4,450	6,675	19
20	<u>Repair and Reseal of Parking Lot</u>	2016	20,930		15	698	698	698	20
21	<u>Water Pipe Repair</u>	2016	5,157		7	368	368	368	21
22	<u>Air Conditioner</u>	2016	6,368		15	212	212	212	22
23	<u>Nurse Call System Replacement</u>	2016	5,988		7	428	428	428	23
24	<u>Tiling/Carpeting-6 Shower Rooms, 11 Patient Rooms, Halls</u>	2016	97,105		15	3,237	3,237	3,237	24
25									25
26									26
27	<u>Land Improvements Booked</u>			2,258			(2,258)		27
28	<u>Building Booked</u>			19,325			(19,325)		28
29	<u>Building Improvement Booked</u>			41,622			(41,622)		29
30									30
31	<u>2016-Home Office Allocation-Building Improvements</u>		10,468			251	251		31
32	<u>2016-Home Office Allocation-Land Improvements</u>		963			63	63		32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,549,862	\$ 63,205		\$ 64,848	\$ 1,643	\$ 1,373,407	34

**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	\$43,713	\$3,357	\$3,984	\$627	5-10 yrs.	\$30,186	71
72	Current Year Purchases	8,484	551	606	55	7 yrs.	606	72
73	Fully Depreciated Assets	188,358					188,358	73
74	Home Office Allocation			12,250	12,250			74
75	TOTALS	\$240,555	\$3,908	\$16,840	\$12,932		\$219,150	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	2000 Town & Country	2002	35,088	1,775	\$	\$(1,775)		\$35,088	76
77										77
78										78
79										79
80	TOTALS			\$35,088	\$1,775	\$	\$(1,775)		\$35,088	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)	\$2,876,126	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$68,888	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$81,688	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$12,800	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$1,627,645	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	Nurses Station	\$37,248	92
93			93
94			94
95		\$37,248	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: \$ 20,267
- 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			\$ 958.00	\$ 12,983	17
18	N/A				18
19					19
20					20
21	TOTAL		\$ 958.00	\$ 12,983	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.

Kewanee Care Home
0053132
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	\$	14,504
Dishwasher		933
Copier		3,809
Home Office Allocation		1,021
		<u>20,267</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)	\$			

- (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.

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	

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	\$	9,985	\$ 148,273	\$	9,985	\$ 148,273	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2,046	30,691		2,046	30,691	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		11,584	173,766		11,584	173,766	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				90,074		90,074	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	23,615	\$ 352,730	\$ 90,074	23,615	\$ 442,804	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	\$ 785,294	\$ 785,294	1
2	Cash-Patient Deposits	15,097	15,097	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 284,093)	1,141,342	1,141,342	3
4	Supply Inventory (priced at Cost)	12,965	12,965	4
5	Short-Term Investments			5
6	Prepaid Insurance	23,845	43,879	6
7	Other Prepaid Expenses	104,094	135,352	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Ppd Lease & Emp. Loans	3,608	3,608	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,086,245	\$ 2,137,537	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		50,621	13
14	Buildings, at Historical Cost		1,806,969	14
15	Leasehold Improvements, at Historical Cost	3,552	742,893	15
16	Equipment, at Historical Cost	40,134	275,643	16
17	Accumulated Depreciation (book methods)	(32,783)	(1,627,645)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		228,631	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(20,577)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):		37,248	22
23	Other(specify): Fund Balance Reserves		288,020	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 10,903	\$ 1,781,803	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,097,148	\$ 3,919,340	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 630,897	\$ 630,897	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	95,932	95,932	30
31	Accrued Taxes Payable (excluding real estate taxes)	208,821	208,821	31
32	Accrued Real Estate Taxes(Sch.IX-B)		57,276	32
33	Accrued Interest Payable		11,749	33
34	Deferred Compensation	5,852	5,852	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	2,077	2,077	36
37	Accrued Management Fees	2,640	2,640	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 946,219	\$ 1,015,244	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,662,160	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Intercompany Loans	1,732,729	(126,267)	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,732,729	\$ 3,535,893	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,678,948	\$ 4,551,137	46
47	TOTAL EQUITY(page 18, line 24)	\$ (581,800)	\$ (631,797)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,097,148	\$ 3,919,340	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,646,834)	1
2	Restatements (describe):		2
3	Prior Period Adjustments Made After Cost Report Was Filed	(1,998)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,648,832)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	941,731	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	125,301	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)	\$ 1,067,032	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)	\$ (581,800)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Kewanee Care Home

0053132

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	\$ 3,972,878	1
2	Discounts and Allowances for all Levels	(296,801)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,676,077	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	652,766	6
7	Oxygen	1,525	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 654,291	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	4,929	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	146,646	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	17,522	20
21	Other Medical Services	24,515	21
22	Laundry	81	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 193,693	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	62	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 62	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Transportation Revenue</u>	10,946	28
28a	<u>Miscellaneous Revenue</u>	794	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 11,740	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,535,863	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	652,367	31
32	Health Care	1,600,544	32
33	General Administration	611,908	33
	B. Capital Expense		
34	Ownership	407,784	34
	C. Ancillary Expense		
35	Special Cost Centers	150,432	35
36	Provider Participation Fee	171,097	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,594,132	40
41	Income before Income Taxes (line 30 minus line 40)**	941,731	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 941,731	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,003,069	44
45	Private Pay - Net Inpatient Revenue	926,074	45
46	Medicare - Net Inpatient Revenue	616,176	46
47	Other-(specify) <u>Insurance Net Inpatient Revenue</u>	130,758	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,676,077	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	2,783	2,923	\$ 72,661	\$ 24.86	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,058	7,138	148,243	20.77	3
4	Licensed Practical Nurses	13,023	13,622	236,346	17.35	4
5	CNAs & Orderlies	42,834	43,654	539,775	12.36	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,080	2,080	25,903	12.45	9
10	Activity Assistants	803	848	9,167	10.81	10
11	Social Service Workers	1,300	1,372	19,370	14.12	11
12	Dietician					12
13	Food Service Supervisor	2,040	2,040	25,972	12.73	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,043	13,363	119,116	8.91	15
16	Dishwashers					16
17	Maintenance Workers	1,996	2,052	34,979	17.05	17
18	Housekeepers	11,494	11,643	98,955	8.50	18
19	Laundry	4,954	5,161	49,698	9.63	19
20	Administrator	2,080	2,080	60,805	29.23	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,080	2,080	31,221	15.01	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>See PG20A</u>	5,865	5,950	104,389	17.54	33
34	TOTAL (lines 1 - 33)	113,433	116,006	\$ 1,576,600 *	\$ 13.59	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	12,000	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	5,127	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 17,127		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.

Kewanee Care Home
0053132
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	2,575	2,639	59,810	22.66
Transportation	1,718	1,739	19,940	11.47
Marketing	1,572	1,572	24,639	15.67
TOTAL	5,865	5,950	104,389	

XIX. SUPPORT SCHEDULES

[illegible]

*** Attach copy of IMRF notifications**

****See instructions.**

Kewanee Care Home
0053132
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)		16,418
Home Office Allocation		
Lucie, Scalf, and Bougher	Legal	55
Miscellaneous	Legal	18
Miller Hall and Triggs	Legal	96
Healthcare Resources International	Legal	478
Hunziker Law	Legal	114
Lexis Nexis	Legal	10
Illinois Secretary of State	Legal	102
Capital Finance Group	Legal	250
CliftonLarson Allen	Accountants	497
Ginoli & Co.	Accountants	8,845
Capital Finance Group	Accountants	6,590
Miscellaneous	Computer Services	63
Change Healthcare	Computer Services	9
PTC Select	Computer Services	6
Advanced Answers on Demand	Computer Services	4,366
Stratus Networks	Computer Services	444
Kemper Technology	Computer Services	293
AT&T	Computer Services	6
Ability Network	Computer Services	1,862
CIAN	Computer Services	222
Comcast	Computer Services	36
CCH	Computer Services	15
Charter Communications	Computer Services	43
Allscripts	Computer Services	649
ATS	Computer Services	293
Allpayer Exchange	Computer Services	15
Optimizer	Other Prof Fees	45
Ankura	Other Prof Fees	339
David Budde	Other Prof Fees	39
Bruner, Cooper, Zuck	Other Prof Fees	99
Marotta, Gund, Budd, Dzerda	Other Prof Fees	4,677
Professional Software and Services	Other Prof Fees	24
Hughes Valuation Services	Other Prof Fees	31
Alan Litwiller	Other Prof Fees	2

Total (agree to Schedule V, line 19, column 8)	<u><u>47,051</u></u>
--	----------------------

XX. GENERAL INFORMATION:

(1)

Are nursing employees (RN,LPN,NA) represented by a union?

No

(2)

Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount.

Yes
IHCA \$1000

(3)

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

No
N/A

(4)

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

No
N/A

(5)

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

Yes
7 yrs.

(6)

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

\$ 22,975 Line 10

(7)

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

Yes

(8)

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

No
N/A

(9)

Are you presently operating under a sublease agreement?

YES X NO

(10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?
YES NO X
If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11)

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

\$ 171,097

(12)

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

No

(13)

Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

Yes

(14)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?
For example, is a portion of the building used for rental, a pharmacy, day care, etc.)
If YES, attach a schedule which explains how all related costs were allocated to these functions.

No

(15)

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

\$ 0
Yes
Indicate the amount. \$ 4,929

(16)

Travel and Transportation

a.

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

No

b.

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

Yes
\$ 10,946

c.

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

100

d.

Have vehicle usage logs been maintained?

Adequate records have been maintained.

e.

Are all vehicles stored at the nursing home during the night and all other times when not in use?

Yes

f.

Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

Yes

g.

Does the facility transport residents to and from day training?
Indicate the amount of income earned from providing such transportation during this reporting period.

No
\$ N/A

(17)

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

Yes
Ginoli and Company

(18)

Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

Yes

(19)

Has a schedule for the legal fees reported on the cost report been provided by the facility?
See page 39 of the instructions for details.
Attach invoices and a summary of services for all architect and appraisal fees

No

RECONCILIATION REPORT			Kewanee Care Home		10:47 AM	7/7/2017							
ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-222,242	equal to	-222,242	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	150,263	equal to	150,263	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	58,003	equal to	58,003	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	9,145	equal to	9,145	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	81,688	equal to	81,688	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	33,250	equal to	33,250	0	FAILED	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to	0	0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	352,730	equal to	352,730	0	O.K.	Pg16 Z12+Z14..	N/A,B	1-4,40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv.- Supplies	90,074	equal to	90,074	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	652,367	equal to	652,367	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	1,600,544	equal to	1,600,544	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	611,908	equal to	611,908	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	407,784	equal to	407,784	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	150,432	equal to	150,432	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..,H24+I	N/A	38to41+43	4
Income Stat. Prov. Partic.	171,097	equal to	171,097	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	1,056,835	equal to	1,056,835	0	O.K.	Pg20 K11..,K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	55,010	equal to	55,010	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	19,370	equal to	19,370	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	145,088	equal to	145,088	0	O.K.	Pg20 K22..,K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	34,979	equal to	34,979	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	98,955	equal to	98,955	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	49,698	equal to	49,698	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	60,805	equal to	60,805	0	O.K.	Pg20 K30..,K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	31,221	equal to	31,221	0	O.K.	Pg20 K33..,K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	1,576,600	equal to	1,515,795	60,805	FAILED	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	0	< or = to		#VALUE!	#VALUE!	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	12,000	< or = to	12,000	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	5,127	< or = to	7,836	-2,709	O.K.	Pg20 X14..,X16+	B. & C.	7to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to		#VALUE!	#VALUE!	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	0	< or = to		0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	60,805	equal to	60,805	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	302,200	equal to	302,200	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	16,418	equal to	16,418	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	223,656	equal to	223,656	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	9,688	equal to	9,688	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	53	equal to	53	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	171,097	equal to	171,097	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..,U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	2,621	equal to	3,145	-524	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	-145,114	equal to	-145,114	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4I	B.	14	8
Total loan balance	3,662,160	equal to	3,662,160	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27.	N/A	29+39-41	2
Real estate tax accrual	57,276	equal to	57,276	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	50,621	equal to	50,621	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	2,549,862	equal to	2,549,862	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	275,643	equal to	275,643	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	1,627,645	equal to	1,627,645	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	-581,800	equal to	-581,800	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	941,731	equal to	941,731	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..,I	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	2,097,148	equal to	2,097,148	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	145,088	14,160	0	159,248	0	159,248	4,870	164,118
2. Food Purchase	0	150,512	0	150,512	0	150,512	-4,841	145,671
3. Housekeeping	98,955	22,045	0	121,000	0	121,000	85	121,085
4. Laundry	49,698	17,425	0	67,123	0	67,123	0	67,123
5. Heat and Other Utilities	0	0	46,287	46,287	0	46,287	284	46,571
6. Maintenance	34,979	18,494	54,724	108,197	0	108,197	10,500	118,697
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	328,720	222,636	101,011	652,367	0	652,367	10,898	663,265
9. Medical Director	0	0	12,000	12,000	0	12,000	0	12,000
10. Nursing & Medical Records	1,056,835	96,763	7,836	1,161,434	0	1,161,434	-495	#####
10a. Therapy	0	0	352,730	352,730	0	352,730	0	352,730
11. Activities	55,010	0	0	55,010	0	55,010	-10,946	44,064
12. Social Services	19,370	0	0	19,370	0	19,370	0	19,370
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	1,131,215	96,763	372,566	1,600,544	0	1,600,544	-11,441	#####
17. Administrative	0	0	302,200	302,200	0	302,200	-241,395	60,805
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	16,418	16,418	0	16,418	30,632	47,050
20. Fees, Subscriptions & Promotion	0	0	9,444	9,444	0	9,444	244	9,688
21. Clerical & General Office	31,221	7,063	18,997	57,281	0	57,281	59,114	116,395
22. Employee Benefits & Payroll	0	0	191,909	191,909	0	191,909	31,747	223,656
23. Inservice Training & Education	0	0	728	728	0	728	109	837
24. Travel and Seminar	0	0	0	0	0	0	53	53
25. Other Admin. Staff Trans	0	0	13,014	13,014	0	13,014	4,467	17,481
26. Insurance-Prop.Liab.Malpractice	0	0	20,914	20,914	0	20,914	29,123	50,037
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	31,221	7,063	573,624	611,908	0	611,908	-85,906	526,002
29. Total General Administrative	1,491,156	326,462	1,047,201	2,864,819	0	2,864,819	-86,449	#####
30. Depreciation	0	0	2,072	2,072	0	2,072	79,616	81,688
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	9,145	9,145
32. Interest	0	0	0	0	0	0	150,263	150,263
33. Real Estate	0	0	0	0	0	0	58,003	58,003
34. Rent - Facility & Grounds	0	0	373,483	373,483	0	373,483	-373,483	0
35. Rent - Equipment & Vehicles	0	0	32,229	32,229	0	32,229	1,021	33,250
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	407,784	407,784	0	407,784	-75,435	332,349
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	90,074	0	90,074	0	90,074	0	90,074
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. Other (specify):*	0	0	171,097	171,097	0	171,097	0	171,097
43. Other (specify):*	24,639	1,350	34,369	60,358	0	60,358	-60,358	0
44. Total Special Cost Ce	24,639	91,424	205,466	321,529	0	321,529	-60,358	261,171
45. Grand Total	1,515,795	417,886	1,660,451	3,594,132	0	3,594,132	-222,242	#####

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	785,294	785,294
2. Cash - Patient Deposits	15,097	15,097
3. Accounts & Notes Recievable	1,141,342	1,141,342
4. Supply Inventory	12,965	12,965
5. Short-Term Investments	0	0
6. Prepaid Insurance	23,845	43,879
7. Other Prepaid Expenses	104,094	135,352
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	3,608	3,608
10. Total current assets	2,086,245	2,137,537
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	0	50,621
14. Buildings, at Historical Cost	0	1,806,969
15. Leasehold Improvements, Historical Cost	3,552	742,893
16. Equipment, at Historical Cost	40,134	275,643
17. Accumulated Depreciation (book methods)	-32,783	-1,627,645
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	228,631
20. Accum Amort - Org/Pre-Op Costs	0	-20,577
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	37,248
23. other (specify):	0	288,020
24. Total Long-Term Assets	10,903	1,781,803
25. Total Assets	2,097,148	3,919,340
CURRENT LIABILITIES		
26. Accounts Payable	630,897	630,897
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	95,932	95,932
31. Accrued Taxes Payable	208,821	208,821
32. Accrued Real Estate Taxes	0	57,276
33. Accrued Interest Payable	0	11,749
34. Deferred Compensation	5,852	5,852
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	2,077	2,077
37. Other Current Liabilities (specify):	2,640	2,640
38. Total Current Liabilities	946,219	1,015,244
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	3,662,160
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	1,732,729	-126,267
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	1,732,729	3,535,893
46.Total Liabilities	2,678,948	4,551,137
47.Total Equity	-581,800	-631,797
48.Total Liabilities and Equity	2,097,148	3,919,340

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	3,972,878
2. Discounts and Allowances for all Levels	-296,801
Subtotal - Inpatient Care	3,676,077
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	652,766
7. Oxygen	1,525
Subtotal - Anciliary Revenue	654,291
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	4,929
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	146,646
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiology and X-Ray	17,522
21. Other Medical Services	24,515
22. Laundry	81
Subtotal - Other Operating Revenue	193,693
24. Contributions	0
25. Interest and Other Investments Income	62
Subtotal - Non-Operating Revenue	62
27. Other Revenue (specify):	10,946
28. Other Revenue (specify):	794
Subtotal - Other Revenue	11,740
30. Total Revenue	4,535,863
31. General Services	663,559
32. Health Care	1,533,645
33. General Administration	588,587
34. Ownership	417,940
35. Special Cost Centers	343,790
35. Provider Participation Fee	166,874
37. Other	0
40. Total Expenses	3,714,395
41. Income Before Income Taxes	821,468
42. Income Taxes	0
43. Net Income or Loss for the Year	821,468