

		FOR BHF USE					

LL1

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: 0053116

Facility Name: Newman Rehab & Hlth Care Ctr

Address: 418 S Memorial Pk Rd Newman 61942
Number City Zip Code

County: Douglas

Telephone Number: (217) 837-2421 Fax # (217) 837-2631

HFS ID Number:

Date of Initial License for Current Owners: 10/1/2005

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) 689-5850
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

Officer or
Administrator
of Provider

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

Paid
Preparer

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

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

Facility Name & ID Number Newman Rehab & Hlth Care Ctr

0053116 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	60	Skilled (SNF)	60	21,900	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	60	TOTALS	60	21,900	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	6,311	6,018	2,000	14,329	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	6,311	6,018	2,000	14,329	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.43%

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 X NO

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

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 X Date 10/1/2005 NO

K. Was the facility certified for Medicare during the reporting year? YES X NO If YES, enter number of beds certified 60 and days of care provided 1,485

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

MODIFIED

ACCRUAL X CASH* CASH*

Is your fiscal year identical to your tax year? YES X 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 Newman Rehab & Hlth Care Ctr # 0053116 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	111,984	8,861		120,845		120,845	2,943	123,788			1
2	Food Purchase		90,722		90,722		90,722	(2,026)	88,696			2
3	Housekeeping	113,457	12,491		125,948		125,948	51	125,999			3
4	Laundry		4,767		4,767		4,767		4,767			4
5	Heat and Other Utilities			51,274	51,274		51,274	171	51,445			5
6	Maintenance	33,050	10,838	23,848	67,736		67,736	1,607	69,343			6
7	Other (specify):* Home Office Ben. Allocation											7
8	TOTAL General Services	258,491	127,679	75,122	461,292		461,292	2,746	464,038			8
	B. Health Care and Programs											
9	Medical Director			15,600	15,600		15,600		15,600			9
10	Nursing and Medical Records	727,834	79,261	10,678	817,773		817,773	(528)	817,245			10
10a	Therapy		53	253,676	253,729		253,729		253,729			10a
11	Activities	28,686	102	29	28,817		28,817	(10,663)	18,154			11
12	Social Services	31,571			31,571		31,571		31,571			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Office Ben. Allocation											15
16	TOTAL Health Care and Programs	788,091	79,416	279,983	1,147,490		1,147,490	(11,191)	1,136,299			16
	C. General Administration											
17	Administrative			219,600	219,600		219,600	(162,267)	57,333			17
18	Directors Fees											18
19	Professional Services			7,686	7,686		7,686	19,049	26,735			19
20	Dues, Fees, Subscriptions & Promotions			5,486	5,486		5,486	313	5,799			20
21	Clerical & General Office Expenses	30,910	1,193	10,291	42,394		42,394	34,313	76,707			21
22	Employee Benefits & Payroll Taxes			134,826	134,826		134,826	19,186	154,012			22
23	Inservice Training & Education							66	66			23
24	Travel and Seminar							32	32			24
25	Other Admin. Staff Transportation			4,876	4,876		4,876	2,699	7,575			25
26	Insurance-Prop.Liab.Malpractice			30,978	30,978		30,978	380	31,358			26
27	Other (specify):* Home Office Ben. Allocation											27
28	TOTAL General Administration	30,910	1,193	413,743	445,846		445,846	(86,229)	359,617			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,077,492	208,288	768,848	2,054,628		2,054,628	(94,674)	1,959,954			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			24,803	24,803		24,803	6,305	31,108			30
31	Amortization of Pre-Op. & Org.							20,235	20,235			31
32	Interest							30,421	30,421			32
33	Real Estate Taxes			19,699	19,699		19,699	175	19,874			33
34	Rent-Facility & Grounds			207,083	207,083		207,083		207,083			34
35	Rent-Equipment & Vehicles			34,726	34,726		34,726	617	35,343			35
36	Other (specify):*											36
37	TOTAL Ownership			286,311	286,311		286,311	57,753	344,064			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		43,353		43,353		43,353		43,353			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			107,667	107,667		107,667		107,667			42
43	Other (specify):*		378	20,567	20,945		20,945	(20,945)				43
44	TOTAL Special Cost Centers		43,731	128,234	171,965		171,965	(20,945)	151,020			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,077,492	252,019	1,183,393	2,512,904		2,512,904	(57,866)	2,455,038			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	(2,079)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,506)	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	(1,288)	30		9
10	Interest and Other Investment Income	(124)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(170)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(6,464)	43		18
19	Entertainment				19
20	Contributions		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	(5,000)	43		24
25	Fund Raising, Advertising and Promotional	(1,022)	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	(16,061)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (35,714)		\$	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)	(22,152)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (22,152)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (57,866)		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	\$ (1,792)	43	1
2	X-Rays-Part A	(1,320)	43	2
3	Resident Flower	(444)	43	3
4	Disallowed Special Events	(1,227)	43	4
5	Offset Transportation Revenue	(10,663)	11	5
6	Offset Miscellaneous Nursing Supplies Revenue	(615)	10	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
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	(16,061)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Newman Rehab & Hlth Care Ctr# 0053116

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	2,943	0	0	0	0	0	0	0	0	0	2,943	1
2	Food Purchase	(2,079)	53	0	0	0	0	0	0	0	0	0	(2,026)	2
3	Housekeeping	0	51	0	0	0	0	0	0	0	0	0	51	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	171	0	0	0	0	0	0	0	0	0	171	5
6	Maintenance	0	1,607	0	0	0	0	0	0	0	0	0	1,607	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,079)	4,825	0	0	0	0	0	0	0	0	0	2,746	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	(615)	87	0	0	0	0	0	0	0	0	0	(528)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(10,663)	0	0	0	0	0	0	0	0	0	0	(10,663)	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	(11,278)	87	0	0	0	0	0	0	0	0	0	(11,191)	16
	C. General Administration													
17	Administrative	0	(162,267)	0	0	0	0	0	0	0	0	0	(162,267)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	7,495	0	11,554	0	0	0	0	0	0	0	19,049	19
20	Fees, Subscriptions & Promotions	0	0	313	0	0	0	0	0	0	0	0	313	20
21	Clerical & General Office Expenses	0	0	34,313	0	0	0	0	0	0	0	0	34,313	21
22	Employee Benefits & Payroll Taxes	0	0	19,186	0	0	0	0	0	0	0	0	19,186	22
23	Inservice Training & Education	0	0	66	0	0	0	0	0	0	0	0	66	23
24	Travel and Seminar	0	0	32	0	0	0	0	0	0	0	0	32	24
25	Other Admin. Staff Transportation	0	0	2,699	0	0	0	0	0	0	0	0	2,699	25
26	Insurance-Prop.Liab.Malpractice	0	0	380	0	0	0	0	0	0	0	0	380	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	(154,772)	56,989	11,554	0	0	0	0	0	0	0	(86,229)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(13,357)	(149,860)	56,989	11,554	0	0	0	0	0	0	0	(94,674)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Newman Rehab & Hlth Care Ctr # 0053116 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	(1,288)	0	7,593	0	0	0	0	0	0	0	0	6,305	30
31	Amortization of Pre-Op. & Org.	0	0	0	20,235	0	0	0	0	0	0	0	20,235	31
32	Interest	(124)	0	223	30,322	0	0	0	0	0	0	0	30,421	32
33	Real Estate Taxes	0	0	175	0	0	0	0	0	0	0	0	175	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	617	0	0	0	0	0	0	0	0	617	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(1,412)	0	8,608	50,557	0	0	0	0	0	0	0	57,753	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):*	(20,945)	0	0	0	0	0	0	0	0	0	0	(20,945)	43
44	TOTAL Special Cost Centers	(20,945)	0	0	0	0	0	0	0	0	0	0	(20,945)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(35,714)	(149,860)	65,597	62,111	0	0	0	0	0	0	0	(57,866)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark B. Petersen	100	See PG6-Supp		See PG6-Supp		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	\$	Petersen Health Care Management, Inc.	100.00%	\$ 2,943	\$ 2,943	1
2	V	2	Food		Petersen Health Care Management, Inc.	100.00%	53	53	2
3	V	3	Housekeeping		Petersen Health Care Management, Inc.	100.00%	51	51	3
4	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	171	171	4
5	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	1,607	1,607	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%	87	87	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	219,600	Petersen Health Care Management, Inc.	100.00%	57,333	(162,267)	11
12	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	7,495	7,495	12
13	V								13
14	Total			\$ 219,600			\$ 69,740	\$ * (149,860)	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%	\$ 313	\$ 313	15
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	34,313	34,313	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	19,186	19,186	17
18	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	66	66	18
19	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	32	32	19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	2,699	2,699	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	380	380	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%	7,593	7,593	23
24	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	223	223	24
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	175	175	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	617	617	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			\$			\$ 65,597	\$ * 65,597	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%	11,554	11,554	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%	20,235	20,235	34
35	V	32	Interest		Petersen Health Wellness, LLC	100.00%	30,322	30,322	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			\$			\$ 62,111	\$ * 62,111	39

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

Facility Name & ID Number

Newman Rehab & Hlth Care Ctr

0053116

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

Newman Rehab & Hlth Care Ctr

0053116

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

Newman Rehab & Hlth Care Ctr

0053116

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 Newman Rehab & Hlth Care Ctr # 0053116 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 Newman Rehab & Hlth Care Ctr# 0053116

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	14,329	\$ 2,943	1
2	2	Food	Resident Days	75	5,673	0	14,329	53	2
3	3	Housekeeping	Resident Days	75	5,456	2,897	14,329	51	3
4	5	Utilities	Resident Days	75	18,209	0	14,329	171	4
5	6	Maintenance	Resident Days	75	170,632	137,057	14,329	1,607	5
6	7	Mgmt. Allocation of Benefits	Resident Days	75	0	0	14,329	0	6
7	9	Medical Director	Resident Days	75	0	0	14,329	0	7
8	10	Nursing and Medical Records	Resident Days	75	9,261	1,782,521	14,329	87	8
9	10A	Therapy	Resident Days	75	0	0	14,329	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	75	0	0	14,329	0	10
11	17	Administrative	Resident Days	75	4,806,228	5,473,961	14,329	57,333	11
12	19	Professional Services	Resident Days	75	795,918	0	14,329	7,495	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	75	33,278	0	14,329	313	13
14	21	Clerical and General Office	Resident Days	75	3,643,535	3,756,135	14,329	34,313	14
15	22	Employee Benefits and Payroll Ta	Resident Days	75	2,037,314	0	14,329	19,186	15
16	23	Inservice Training & Education	Resident Days	75	6,986	0	14,329	66	16
17	24	Travel and Seminar	Resident Days	75	3,389	0	14,329	32	17
18	25	Other Admin. Staff Transport.	Resident Days	75	286,637	0	14,329	2,699	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	75	40,378	0	14,329	380	19
20	27	Mgmt. Allocation of Benefits	Resident Days	75	0	0	14,329	0	20
21	30	Depreciation	Resident Days	75	806,271	0	14,329	7,593	21
22	32	Interest	Resident Days	75	23,686	0	14,329	223	22
23	33	Real Estate Taxes	Resident Days	75	18,560	0	14,329	175	23
24	35	Rent-Equipment & Vehicles	Resident Days	75	65,550	0	14,329	617	24
25	TOTALS				\$ 13,089,501	\$ 11,510,481		\$ 135,337	25

Facility Name & ID Number Newman Rehab & Hlth Care Ctr# 0053116

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	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6			
1	1	Dietary	Resident Days	94,948	7	\$	\$	14,329	\$	1
2	2	Food	Resident Days	94,948	7			14,329		2
3	3	Housekeeping	Resident Days	94,948	7			14,329		3
4	4	Laundry	Resident Days	94,948	7			14,329		4
5	5	Utilities	Resident Days	94,948	7			14,329		5
6	6	Maintenance	Resident Days	94,948	7			14,329		6
7	7	Mgmt. Allocation of Benefits	Resident Days	94,948	7			14,329		7
8	10	Nursing and Medical Records	Resident Days	94,948	7			14,329		8
9	15	Mgmt. Allocation of Benefits	Resident Days	94,948	7			14,329		9
10	17	Administrative	Resident Days	94,948	7			14,329		10
11	19	Professional Services	Resident Days	94,948	7	76,557		14,329	11,554	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	94,948	7			14,329		12
13	21	Clerical and General Office	Resident Days	94,948	7			14,329		13
14	22	Employee Benefits & Payroll	Resident Days	94,948	7			14,329		14
15	23	Inservice Training & Education	Resident Days	94,948	7			14,329		15
16	24	Travel and Seminar	Resident Days	94,948	7			14,329		16
17	25	Other Admin. Staff Transport.	Resident Days	94,948	7			14,329		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	94,948	7			14,329		18
19	30	Depreciation	Resident Days	94,948	7			14,329		19
20	31	Amortization	Resident Days	94,948	7	134,086		14,329	20,235	20
21	32	Interest	Resident Days	94,948	7	200,924		14,329	30,322	21
22	33	Real Estate Taxes	Resident Days	94,948	7			14,329		22
23	34	Rent-Facility and Grounds	Resident Days	94,948	7			14,329		23
24	35	Rent-Equipment & Vehicles	Resident Days	94,948	7			14,329		24
25	TOTALS					\$ 411,567	\$		\$ 62,111	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								Interest Income Offset				(124)	10
11								Home Office Allocation-PHCM				223	11
12								Home Office Allocation-PHW				30,322	12
13													13
14	TOTAL Non-Facility Related						\$	\$			\$	30,421	14
15	TOTALS (line 9+line14)						\$	\$			\$	30,421	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.)

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Newman Rehab & Hlth Care Ctr COUNTY Douglas

FACILITY IDPH LICENSE NUMBER 0053116

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. 07-06-31-400-012	Long-Term Care Facility	\$ 19,926.82	\$ 19,926.82
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 19,926.82	\$ 19,926.82

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

20,206

B. General Construction Type:

Exterior

Brick

Frame

Protected

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:

188,175

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

20

3. Current Period Amortization:

20,235

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:

1		2		3		4	
Use		Square Feet		Year Acquired		Cost	
1	Facility	20,206		2005			1
2							2
3	TOTALS	20,206				\$	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						\$			\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Sidewalks		2006		5,535		8			5,535
10	2 Rooftop A/C		2006		11,726		5			11,726
11	Roof		2007		43,864		20	2,193	2,193	20,834
12	Water Heater		2007		25,462		10	2,546	2,546	24,187
13	Rooftop Unit		2011		7,350		15	490	490	2,695
14	Rooftop Unit		2011		6,925		15	462	462	2,541
15	Sand Filter		2012		5,000		7	714	714	3,213
16	Roof Replacement		2013		38,675		25	1,548	1,548	5,418
17	Nurses Station		2013		6,947		15	464	464	1,624
18	Flooring for Bathroom		2013		11,775		15	786	786	1,946
19	Water Heater		2014		6,029		7	862	862	2,155
20	Carpeting Replacement in Hallway and Main Level		2014		12,855		15	857	857	2,143
21	Compressor Repair		2014		4,033		7	576	576	1,440
22	Concrete Repair		2014		2,650		7	189	189	567
23	A/C Condenser Units		2014		5,625		15	375	375	938
24	Nurses Station		2015		19,150		15	1,278	1,278	1,917
25										25
26										26
27										27
28										28
29										29
30										30
31	Land Improvements Booked					369			(369)	
32	Building Improvement Booked					10,740			(10,740)	
33										33
34	2016-Home Office Allocation-Building Improvements				6,326			152	152	
35	2016-Home Office Allocation-Land Improvements				582			38	38	
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

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)		\$ 220,509	\$ 11,109		\$ 13,530	\$ 2,421	\$ 88,879	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	\$101,755	\$13,694	\$10,175	\$(3,519)	5-10 yrs.	\$30,377	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	12,150					12,150	73
74	Home Office Allocation			7,403	7,403			74
75	TOTALS	\$113,905	\$13,694	\$17,578	\$3,884		\$42,527	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 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)	\$334,414	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$24,803	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$31,108	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$6,305	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$131,406	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		\$	92
93			93
94	N/A		94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Springwood Associates Limited Partnership
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:		60	12/1/1992	\$ 207,083	10	N/A	3
4	Additions							4
5								5
6								6
7	TOTAL		60		\$ 207,083			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
- 207,083

.

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: \$ 28,405
- Description: See Attached Schedule 14A
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2012 Ford E150	\$ 578.00	\$ 6,938	17
18					18
19					19
20					20
21	TOTAL		\$ 578.00	\$ 6,938	21

10. Effective dates of current rental agreement:

Beginning 12/1/1992

Ending 10/1/2018

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2017</u>	\$ <u>210,478</u>
13.	<u>/2018</u>	\$ <u>210,478</u>
14.	<u>/2019</u>	\$ <u>210,478</u>

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

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

Newman Rehab & Hlth Care Ctr
0053116

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	\$ 13,692
Dishwasher	701
Generator	5,079
Copier	8,316
Home Office Allocation	<u>617</u>
	<u><u>28,405</u></u>

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

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

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

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(2), 10A(3)	hrs	\$	6,939	\$ 104,082	\$ 53	6,939	\$ 104,135	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2,423	36,344		2,423	36,344	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		7,550	113,250		7,550	113,250	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				43,353		43,353	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			\$	16,912	\$ 253,676	\$ 43,406	16,912	\$ 297,082	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	\$ (90,195)	\$ (90,195)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 59,279)	918,279	918,279	3
4	Supply Inventory (priced at Cost)	7,621	7,621	4
5	Short-Term Investments			5
6	Prepaid Insurance	13,661	13,661	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Security Deposit	45,797	45,797	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 895,163	\$ 895,163	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	5,535		13
14	Buildings, at Historical Cost		6,326	14
15	Leasehold Improvements, at Historical Cost	217,066	214,183	15
16	Equipment, at Historical Cost	113,905	113,905	16
17	Accumulated Depreciation (book methods)	(145,119)	(131,406)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Intercompany Loans	582	582	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 191,969	\$ 203,590	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,087,132	\$ 1,098,753	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 727,393	\$ 727,393	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	51,793	51,793	30
31	Accrued Taxes Payable (excluding real estate taxes)	25,861	25,861	31
32	Accrued Real Estate Taxes(Sch.IX-B)	20,520	20,520	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	83,808	83,808	36
37	Accrued Management Fees	118,067	118,067	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,027,442	\$ 1,027,442	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				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,027,442	\$ 1,027,442	46
47	TOTAL EQUITY(page 18, line 24)	\$ 59,690	\$ 71,311	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,087,132	\$ 1,098,753	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (303,775)	1
2	Restatements (describe):		2
3	Prior Period Adjustments Made After Cost Reports Were Filed	(24,170)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (327,945)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	387,635	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)	\$ 387,635	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)	\$ 59,690	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Newman Rehab & Hlth Care Ctr

0053116

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	\$ 2,604,731	1
2	Discounts and Allowances for all Levels	(291,481)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,313,250	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	475,859	6
7	Oxygen	3,410	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 479,269	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	2,079	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	74,216	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	2,717	20
21	Other Medical Services	17,606	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 96,618	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	124	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 124	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Transportation Revenue</u>	10,663	28
28a	<u>Miscellaneous Revenue</u>	615	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 11,278	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,900,539	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	461,292	31
32	Health Care	1,147,490	32
33	General Administration	445,846	33
	B. Capital Expense		
34	Ownership	286,311	34
	C. Ancillary Expense		
35	Special Cost Centers	64,298	35
36	Provider Participation Fee	107,667	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,512,904	40
41	Income before Income Taxes (line 30 minus line 40)**	387,635	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 387,635	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,139,017	44
45	Private Pay - Net Inpatient Revenue	786,329	45
46	Medicare - Net Inpatient Revenue	323,693	46
47	Other-(specify) <u>Insurance Net Inpatient Revenue</u>	64,211	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,313,250	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	1,820	1,820	\$ 59,583	\$ 32.74	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,160	2,359	67,431	28.58	3
4	Licensed Practical Nurses	8,831	9,118	181,069	19.86	4
5	CNAs & Orderlies	31,422	32,358	350,578	10.83	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,912	2,106	28,686	13.62	9
10	Activity Assistants					10
11	Social Service Workers	2,080	2,080	31,571	15.18	11
12	Dietician					12
13	Food Service Supervisor	1,887	1,973	27,344	13.86	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,056	9,249	84,640	9.15	15
16	Dishwashers					16
17	Maintenance Workers	2,080	2,080	33,050	15.89	17
18	Housekeepers	10,441	11,133	113,457	10.19	18
19	Laundry					19
20	Administrator	2,080	2,080	57,333	27.56	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,905	2,090	30,910	14.79	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	958	1,057	23,284	22.03	31
32	Other Health Care(specify)					32
33	Other(specify) CPC	1,996	2,097	45,889	21.88	33
34	TOTAL (lines 1 - 33)	78,628	81,600	\$ 1,134,825 *	\$ 13.91	34

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

** See instructions.

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	15,600	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,086	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	8	477		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)	8	\$ 19,163		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

STATE OF ILLINOIS

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Facility Name & ID Number

Newman Rehab & Hlth Care Ctr

0053116

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name		Function	Ownership %	Amount	Description		Amount	Description		Amount	
Cindy Crable		Administrator	0	\$ 57,333	Workers' Compensation Insurance		\$ 20,304	IDPH License Fee		\$ 1,990	
					Unemployment Compensation Insurance		28,472	Advertising: Employee Recruitment		168	
					FICA Taxes		80,279	Health Care Worker Background Check			
					Employee Health Insurance		4,823	(Indicate # of checks performed 9)		241	
					Employee Meals			Patient Background Checks		23 619	
					Illinois Municipal Retirement Fund (IMRF)*			Miscellaneous Licenses & Permits		968	
					Employee Relations		421	Miscellaneous Dues & Subscriptions		1,500	
					Employee Retirement		527	Home Office Allocation		313	
					Home Office Allocation		19,186				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$ 57,333							
B. Administrative - Other								Less: Public Relations Expense		()	
Description				Amount				Non-allowable advertising		()	
Management Fees-See Page 6, Eliminated on P 3, C 7				\$ 219,600				Yellow page advertising		()	
					TOTAL (agree to Schedule V, line 22, col.8)		\$ 154,012	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 5,799	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$ 219,600	E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**		
Vendor/Payee		Type		Amount	Description		Line #	Amount	Description		Amount
E-Health Data Solutions		Computer Services		\$ 3,042					Out-of-State Travel		\$
Honkamp Krueger & Co.		Accounting Services		937							
Allscripts		Computer Services		962	N/A						
Frontier		Computer Services		1,365					In-State Travel		
Livingston, Barger, Brandt...		Legal Fees		1,380							
									Seminar Expense		
									Home Office Allocation		32
									Entertainment Expense		()
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)				\$ 7,686	TOTAL			\$	(agree to Sch. V, line 24, col. 8)		
									TOTAL		\$ 32

* Attach copy of IMRF notifications

**See instructions.

Newman Rehab & Hlth Care Ctr
0053116
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)		7,686
Home Office Allocation		
Lucie, Scalf, and Bougher	Legal	33
Miscellaneous	Legal	13
Miller Hall and Triggs	Legal	58
Healthcare Resources International	Legal	289
Hunziker Law	Legal	69
Lexis Nexis	Legal	6
Gemino	Legal	5,205
Illinois Secretary of State	Legal	38
Peoria County Recorder	Legal	15
CliftonLarson Allen	Accountants	300
Ginoli & Co.	Accountants	3,051
Miscellaneous	Computer Services	38
Change Healthcare	Computer Services	6
PTC Select	Computer Services	3
Advanced Answers on Demand	Computer Services	2,639
Stratus Networks	Computer Services	268
Kemper Technology	Computer Services	177
AT&T	Computer Services	4
Ability Network	Computer Services	1,125
CIAN	Computer Services	134
Comcast	Computer Services	22
CCH	Computer Services	9
Charter Communications	Computer Services	26
Allscripts	Computer Services	392
ATS	Computer Services	177
Allpayer Exchange	Computer Services	9
Optimizer	Other Prof Fees	27
Ankura	Other Prof Fees	205
David Budde	Other Prof Fees	23
Bruner, Cooper, Zuck	Other Prof Fees	60
Marotta, Gund, Budd, Dzerda	Other Prof Fees	4,595
Professional Software and Services	Other Prof Fees	15
Hughes Valuation Services	Other Prof Fees	18
Alan Litwiller	Other Prof Fees	1

Total (agree to Schedule V, line 19, column 8)	<u><u>26,736</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 \$1500

(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.

\$ 15,739 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.

\$ 107,667

(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. \$ 2,079

(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
\$ 10,663

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			Newman Rehab & Hlth		11:20 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	-57,866	equal to	-57,866	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	30,421	equal to	30,421	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	19,874	equal to	19,874	0	FAILED	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	20,235	equal to	20,235	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	31,108	equal to	31,108	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	207,083	equal to	207,083	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	35,343	equal to	35,343	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to	0	0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	253,729	equal to	253,729	0	O.K.	Pg16 Z12+Z14..	N/A,B	1-4,40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv.- Supplies	43,406	equal to	43,406	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	461,292	equal to	461,292	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	1,147,490	equal to	1,147,490	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	445,846	equal to	445,846	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	286,311	equal to	286,311	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	64,298	equal to	64,298	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..,H24+I	N/A	38to41+43	4
Income Stat. Prov. Partic.	107,667	equal to	107,667	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	727,834	equal to	727,834	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	28,686	equal to	28,686	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	31,571	equal to	31,571	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	111,984	equal to	111,984	0	O.K.	Pg20 K22..,K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	33,050	equal to	33,050	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	113,457	equal to	113,457	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- Administrative	57,333	equal to	57,333	0	O.K.	Pg20 K30..,K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	30,910	equal to	30,910	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	1,134,825	equal to	1,077,492	57,333	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	15,600	< or = to	15,600	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	3,563	< or = to	10,678	-7,115	O.K.	Pg20 X14..,X16+	B. & C.	7to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to	29	-29	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	0	< or = to		0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	57,333	equal to	57,333	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	219,600	equal to	219,600	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	7,686	equal to	7,686	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	154,012	equal to	154,012	0	FAILED	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	5,799	equal to	5,799	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	32	equal to	32	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	107,667	equal to	107,667	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..,U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	1,485	equal to	2,000	-515	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	-22,152	equal to	-22,152	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4I	B.	14	8
Total loan balance	0	equal to	0	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27.	N/A	29+39-41	2
Real estate tax accrual	20,520	equal to	20,520	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	0	equal to		#VALUE!	#VALUE!	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	220,509	equal to	220,509	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	113,905	equal to	113,905	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	131,406	equal to	131,406	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	59,690	equal to	59,690	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	387,635	equal to	387,635	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	1,087,132	equal to	1,087,132	0	O.K.	Pg17:H41	N/A	25	1	Pg17 S41	N/A	48	1

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Total
1. Dietary	111,984	8,861	0	120,845	0	120,845	2,943	123,788
2. Food Purchase	0	90,722	0	90,722	0	90,722	-2,026	88,696
3. Housekeeping	113,457	12,491	0	125,948	0	125,948	51	125,999
4. Laundry	0	4,767	0	4,767	0	4,767	0	4,767
5. Heat and Other Utilities	0	0	51,274	51,274	0	51,274	171	51,445
6. Maintenance	33,050	10,838	23,848	67,736	0	67,736	1,607	69,343
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	258,491	127,679	75,122	461,292	0	461,292	2,746	464,038
9. Medical Director	0	0	15,600	15,600	0	15,600	0	15,600
10. Nursing & Medical Records	727,834	79,261	10,678	817,773	0	817,773	-528	817,245
10a. Therapy	0	53	253,676	253,729	0	253,729	0	253,729
11. Activities	28,686	102	29	28,817	0	28,817	-10,663	18,154
12. Social Services	31,571	0	0	31,571	0	31,571	0	31,571
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	788,091	79,416	279,983	1,147,490	0	1,147,490	-11,191	#####
17. Administrative	0	0	219,600	219,600	0	219,600	-162,267	57,333
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	7,686	7,686	0	7,686	19,049	26,735
20. Fees, Subscriptions & Promotion	0	0	5,486	5,486	0	5,486	313	5,799
21. Clerical & General Office	30,910	1,193	10,291	42,394	0	42,394	34,313	76,707
22. Employee Benefits & Payroll	0	0	134,826	134,826	0	134,826	19,186	154,012
23. Inservice Training & Education	0	0	0	0	0	0	66	66
24. Travel and Seminar	0	0	0	0	0	0	32	32
25. Other Admin. Staff Trans	0	0	4,876	4,876	0	4,876	2,699	7,575
26. Insurance-Prop.Liab.Malpractice	0	0	30,978	30,978	0	30,978	380	31,358
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	30,910	1,193	413,743	445,846	0	445,846	-86,229	359,617
29. Total General Administrative	1,077,492	208,288	768,848	2,054,628	0	2,054,628	-94,674	#####
30. Depreciation	0	0	24,803	24,803	0	24,803	6,305	31,108
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	20,235	20,235
32. Interest	0	0	0	0	0	0	30,421	30,421
33. Real Estate	0	0	19,699	19,699	0	19,699	175	19,874
34. Rent - Facility & Grounds	0	0	207,083	207,083	0	207,083	0	207,083
35. Rent - Equipment & Vehicles	0	0	34,726	34,726	0	34,726	617	35,343
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	286,311	286,311	0	286,311	57,753	344,064
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	43,353	0	43,353	0	43,353	0	43,353
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	107,667	107,667	0	107,667	0	107,667
43. Other (specify):*	0	378	20,567	20,945	0	20,945	-20,945	0
44. Total Special Cost Ce	0	43,731	128,234	171,965	0	171,965	-20,945	151,020
45. Grand Total	1,077,492	252,019	1,183,393	2,512,904	0	2,512,904	-57,866	#####

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	-90,195	-90,195
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	918,279	918,279
4. Supply Inventory	7,621	7,621
5. Short-Term Investments	0	0
6. Prepaid Insurance	13,661	13,661
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	45,797	45,797
10. Total current assets	895,163	895,163
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	5,535	0
14. Buildings, at Historical Cost	0	6,326
15. Leasehold Improvements, Historical Cost	217,066	214,183
16. Equipment, at Historical Cost	113,905	113,905
17. Accumulated Depreciation (book methods)	-145,119	-131,406
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):	582	582
24. Total Long-Term Assets	191,969	203,590
25. Total Assets	1,087,132	1,098,753
CURRENT LIABILITIES		
26. Accounts Payable	727,393	727,393
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	51,793	51,793
31. Accrued Taxes Payable	25,861	25,861
32. Accrued Real Estate Taxes	20,520	20,520
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	83,808	83,808
37. Other Current Liabilities (specify):	118,067	118,067
38. Total Current Liabilities	1,027,442	1,027,442
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):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	0	0
46.Total Liabilities	1,027,442	1,027,442
47.Total Equity	59,690	71,311
48.Total Liabilities and Equity	1,087,132	1,098,753

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	2,604,731
2. Discounts and Allowances for all Levels	-291,481
Subtotal - Inpatient Care	2,313,250
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	475,859
7. Oxygen	3,410
Subtotal - Ancillary Revenue	479,269
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	2,079
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	74,216
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiology and X-Ray	2,717
21. Other Medical Services	17,606
22. Laundry	0
Subtotal - Other Operating Revenue	96,618
24. Contributions	0
25. Interest and Other Investments Income	124
Subtotal - Non-Operating Revenue	124
27. Other Revenue (specify):	10,663
28. Other Revenue (specify):	615
Subtotal - Other Revenue	11,278
30. Total Revenue	2,900,539
31. General Services	448,516
32. Health Care	1,165,781
33. General Administration	426,230
34. Ownership	287,096
35. Special Cost Centers	205,727
35. Provider Participation Fee	110,869
37. Other	0
40. Total Expenses	2,644,219
41. Income Before Income Taxes	256,320
42. Income Taxes	0
43. Net Income or Loss for the Year	256,320