

		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: 0050641 Facility Name: Nokomis Rehab & Hlth Care C Address: 505 Stevens Street, Nokomis, 62075 County: Montgomery Telephone Number: 217-563-7725, Fax #: 217-563-2022 HFS ID Number: Date of Initial License for Current Owners: 8/1/2007 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:

0050641 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

D. How many bed-hold days during this year were paid by the Department?

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

N/A

Meals on Wheels

F. Does the facility maintain a daily midnight census?

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

I. On what date did you start providing long term care at this location?

Date started 8/1/2007

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

YES ☒ Date 8/1/2007 NO ☐

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

YES ☒ NO ☐ If YES, enter number
of beds certified 92 and days of care provided

Medicare Intermediary CGS Administrators

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.

B. Census-For the entire report period.

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 56.56%

Facility Name & ID Number Nokomis Rehab & Hlth Care C # 0050641 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	129,684	11,052		140,736		140,736	3,902	144,638			1
2	Food Purchase		138,070		138,070		138,070	(2,038)	136,032			2
3	Housekeeping	77,089	14,110		91,199		91,199	68	91,267			3
4	Laundry	49,927	11,933		61,860		61,860		61,860			4
5	Heat and Other Utilities			79,798	79,798		79,798	227	80,025			5
6	Maintenance	38,674	9,106	18,052	65,832		65,832	2,130	67,962			6
7	Other (specify):* <u>Home Office Ben. Allocation</u>											7
8	TOTAL General Services	295,374	184,271	97,850	577,495		577,495	4,289	581,784			8
	B. Health Care and Programs											
9	Medical Director			14,250	14,250		14,250		14,250			9
10	Nursing and Medical Records	822,556	80,501	4,503	907,560		907,560	36	907,596			10
10a	Therapy		50	159,899	159,949		159,949		159,949			10a
11	Activities	44,260	97	116	44,473		44,473	(15,072)	29,401			11
12	Social Services	35,604	14		35,618		35,618		35,618			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	902,420	80,662	178,768	1,161,850		1,161,850	(15,036)	1,146,814			16
	C. General Administration											
17	Administrative			216,400	216,400		216,400	(155,238)	61,162			17
18	Directors Fees											18
19	Professional Services			8,151	8,151		8,151	15,815	23,966			19
20	Dues, Fees, Subscriptions & Promotions			9,844	9,844		9,844	375	10,219			20
21	Clerical & General Office Expenses	30,439	2,724	9,154	42,317		42,317	45,414	87,731			21
22	Employee Benefits & Payroll Taxes			159,053	159,053		159,053	25,433	184,486			22
23	Inservice Training & Education							87	87			23
24	Travel and Seminar							42	42			24
25	Other Admin. Staff Transportation			8,422	8,422		8,422	3,578	12,000			25
26	Insurance-Prop.Liab.Malpractice			28,864	28,864		28,864	504	29,368			26
27	Other (specify):* <u>Home Office Ben. Allocation</u>											27
28	TOTAL General Administration	30,439	2,724	439,888	473,051		473,051	(63,990)	409,061			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,228,233	267,657	716,506	2,212,396		2,212,396	(74,737)	2,137,659			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			69,861	69,861		69,861	21,383	91,244			30
31	Amortization of Pre-Op. & Org.							9,123	9,123			31
32	Interest			41,084	41,084		41,084	10,474	51,558			32
33	Real Estate Taxes			53,408	53,408		53,408	232	53,640			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			11,168	11,168		11,168	818	11,986			35
36	Other (specify):*											36
37	TOTAL Ownership			175,521	175,521		175,521	42,030	217,551			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		34,878		34,878		34,878		34,878			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			157,923	157,923		157,923		157,923			42
43	Other (specify):*		176	16,233	16,409		16,409	(16,409)				43
44	TOTAL Special Cost Centers		35,054	174,156	209,210		209,210	(16,409)	192,801			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,228,233	302,711	1,066,183	2,597,127		2,597,127	(49,116)	2,548,011			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	(2,109)	2		4
5	Telephone, TV & Radio in Resident Rooms	(434)	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	10,997	30		9
10	Interest and Other Investment Income	(1,334)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(99)	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	(4,048)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(5,000)	43		24
25	Fund Raising, Advertising and Promotional	(2,600)	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	(19,490)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (24,117)		\$	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)	(24,999)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (24,999)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (49,116)		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	\$ (2,423)	43	1
2	X-Rays-Part A	(1,459)	43	2
3	Disallowed Special Events	(309)	43	3
4	Disallowed Chamber of Commerce Dues	(40)	20	4
5	Offset Miscellaneous Office Supllies	(80)	10	5
6	Offset Transportation Revenue	(15,072)	11	6
7	Offset Miscellaneous Office Supllies	(70)	21	7
8	Disallowed Resident Flower	(37)	43	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	(19,490)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Nokomis Rehab & Hlth Care C# 0050641

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	3,902	0	0	0	0	0	0	0	0	0	3,902	1
2	Food Purchase	(2,109)	71	0	0	0	0	0	0	0	0	0	(2,038)	2
3	Housekeeping	0	68	0	0	0	0	0	0	0	0	0	68	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	227	0	0	0	0	0	0	0	0	0	227	5
6	Maintenance	0	2,130	0	0	0	0	0	0	0	0	0	2,130	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,109)	6,398	0	0	0	0	0	0	0	0	0	4,289	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	(80)	116	0	0	0	0	0	0	0	0	0	36	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(15,072)	0	0	0	0	0	0	0	0	0	0	(15,072)	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	(15,152)	116	0	0	0	0	0	0	0	0	0	(15,036)	16
	C. General Administration													
17	Administrative	0	(155,238)	0	0	0	0	0	0	0	0	0	(155,238)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	9,936	0	5,879	0	0	0	0	0	0	0	15,815	19
20	Fees, Subscriptions & Promotions	(40)	0	415	0	0	0	0	0	0	0	0	375	20
21	Clerical & General Office Expenses	(70)	0	45,484	0	0	0	0	0	0	0	0	45,414	21
22	Employee Benefits & Payroll Taxes	0	0	25,433	0	0	0	0	0	0	0	0	25,433	22
23	Inservice Training & Education	0	0	87	0	0	0	0	0	0	0	0	87	23
24	Travel and Seminar	0	0	42	0	0	0	0	0	0	0	0	42	24
25	Other Admin. Staff Transportation	0	0	3,578	0	0	0	0	0	0	0	0	3,578	25
26	Insurance-Prop.Liab.Malpractice	0	0	504	0	0	0	0	0	0	0	0	504	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(110)	(145,302)	75,543	5,879	0	0	0	0	0	0	0	(63,990)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(17,371)	(138,788)	75,543	5,879	0	0	0	0	0	0	0	(74,737)	29

Summary B

12/31/2016

[illegible]

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	<u>Dietary</u>	\$	<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>\$ 3,902</u>	<u>\$ 3,902</u>	1
2	V	2	<u>Food</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>71</u>	<u>71</u>	2
3	V	3	<u>Housekeeping</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>68</u>	<u>68</u>	3
4	V	5	<u>Utilities</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>227</u>	<u>227</u>	4
5	V	6	<u>Maintenance</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>2,130</u>	<u>2,130</u>	5
6	V	7	<u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>0</u>		6
7	V	9	<u>Medical Director</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>0</u>		7
8	V	10	<u>Nursing and Medical Records</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>116</u>	<u>116</u>	8
9	V	10A	<u>Therapy</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>0</u>		9
10	V	15	<u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>0</u>		10
11	V	17	<u>Administrative</u>	<u>216,400</u>	<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>61,162</u>	<u>(155,238)</u>	11
12	V	19	<u>Professional Services</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>9,936</u>	<u>9,936</u>	12
13	V								13
14	Total			<u>\$ 216,400</u>			<u>\$ 77,612</u>	<u>\$ * (138,788)</u>	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	20	Dues, Fees, Subs & Promotions	\$	Petersen Health Care Management, Inc.	100.00%	\$ 415	\$ 415	15
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	45,484	45,484	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	25,433	25,433	17
18	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	87	87	18
19	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	42	42	19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	3,578	3,578	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	504	504	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%	10,065	10,065	23
24	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	296	296	24
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	232	232	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	818	818	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			\$			\$ 86,954	\$ * 86,954	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

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

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	1 Dietary	\$	Petersen Health Network, LLC	100.00%	\$ 0	\$	15
16	V	2 Food		Petersen Health Network, LLC	100.00%	0		16
17	V	3 Housekeeping		Petersen Health Network, LLC	100.00%	0		17
18	V	4 Laundry		Petersen Health Network, LLC	100.00%	0		18
19	V	5 Utilities		Petersen Health Network, LLC	100.00%	0		19
20	V	6 Maintenance		Petersen Health Network, LLC	100.00%	0		20
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Network, LLC	100.00%	0		21
22	V	10 Nursing and Medical Records		Petersen Health Network, LLC	100.00%	0		22
23	V	15 Mgmt. Allocation of Benefits		Petersen Health Network, LLC	100.00%	0		23
24	V	17 Administrative		Petersen Health Network, LLC	100.00%	0		24
25	V	19 Professional Services		Petersen Health Network, LLC	100.00%	5,879	5,879	25
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Network, LLC	100.00%	0		26
27	V	21 Clerical and General Office		Petersen Health Network, LLC	100.00%	0		27
28	V	22 Employee Benefits & Payroll		Petersen Health Network, LLC	100.00%	0		28
29	V	23 Inservice Training & Education		Petersen Health Network, LLC	100.00%	0		29
30	V	24 Travel and Seminar		Petersen Health Network, LLC	100.00%	0		30
31	V	25 Other Admin. Staff Transport.		Petersen Health Network, LLC	100.00%	0		31
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Network, LLC	100.00%	0		32
33	V	30 Depreciation		Petersen Health Network, LLC	100.00%	321	321	33
34	V	31 Amortization		Petersen Health Network, LLC	100.00%	9,123	9,123	34
35	V	32 Interest		Petersen Health Network, LLC	100.00%	11,512	11,512	35
36	V	33 Real Estate Taxes		Petersen Health Network, LLC	100.00%	0		36
37	V	34 Rent-Facility and Grounds		Petersen Health Network, LLC	100.00%	0		37
38	V	35 Rent-Equipment & Vehicles		Petersen Health Network, LLC	100.00%	0		38
39	Total		\$			\$ 26,835	\$ * 26,835	39

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

Facility Name & ID Number

Nokomis Rehab & Hlth Care C

0050641

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

Nokomis Rehab & Hlth Care C

0050641

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

Nokomis Rehab & Hlth Care C

0050641

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

Nokomis Rehab & Hlth Care C

0050641

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 Nokomis Rehab & Hlth Care C # 0050641 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 Nokomis Rehab & Hlth Care C# 0050641

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	18,994	\$ 3,902	1
2	2	Food	Resident Days	75	5,673	0	18,994	71	2
3	3	Housekeeping	Resident Days	75	5,456	2,897	18,994	68	3
4	5	Utilities	Resident Days	75	18,209	0	18,994	227	4
5	6	Maintenance	Resident Days	75	170,632	137,057	18,994	2,130	5
6	7	Mgmt. Allocation of Benefits	Resident Days	75	0	0	18,994	0	6
7	9	Medical Director	Resident Days	75	0	0	18,994	0	7
8	10	Nursing and Medical Records	Resident Days	75	9,261	1,782,521	18,994	116	8
9	10A	Therapy	Resident Days	75	0	0	18,994	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	75	0	0	18,994	0	10
11	17	Administrative	Resident Days	75	4,899,467	5,473,961	18,994	61,162	11
12	19	Professional Services	Resident Days	75	795,918	0	18,994	9,936	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	75	33,278	0	18,994	415	13
14	21	Clerical and General Office	Resident Days	75	3,643,535	3,756,135	18,994	45,484	14
15	22	Employee Benefits and Payroll Tax	Resident Days	75	2,037,314	0	18,994	25,433	15
16	23	Inservice Training & Education	Resident Days	75	6,986	0	18,994	87	16
17	24	Travel and Seminar	Resident Days	75	3,389	0	18,994	42	17
18	25	Other Admin. Staff Transport.	Resident Days	75	286,637	0	18,994	3,578	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	75	40,378	0	18,994	504	19
20	27	Mgmt. Allocation of Benefits	Resident Days	75	0	0	18,994	0	20
21	30	Depreciation	Resident Days	75	806,271	0	18,994	10,065	21
22	32	Interest	Resident Days	75	23,686	0	18,994	296	22
23	33	Real Estate Taxes	Resident Days	75	18,560	0	18,994	232	23
24	35	Rent-Equipment & Vehicles	Resident Days	75	65,550	0	18,994	818	24
25	TOTALS				\$ 13,182,740	\$ 11,510,481		\$ 164,566	25

Facility Name & ID Number Nokomis Rehab & Hlth Care C# 0050641

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 Network, 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	251,294	13	\$	\$	18,994	\$	1
2	2	Food	Resident Days	251,294	13			18,994		2
3	3	Housekeeping	Resident Days	251,294	13			18,994		3
4	4	Laundry	Resident Days	251,294	13			18,994		4
5	5	Utilities	Resident Days	251,294	13			18,994		5
6	6	Maintenance	Resident Days	251,294	13			18,994		6
7	7	Mgmt. Allocation of Benefits	Resident Days	251,294	13			18,994		7
8	10	Nursing and Medical Records	Resident Days	251,294	13			18,994		8
9	15	Mgmt. Allocation of Benefits	Resident Days	251,294	13			18,994		9
10	17	Administrative	Resident Days	251,294	13			18,994		10
11	19	Professional Services	Resident Days	251,294	13	77,776		18,994	5,879	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	251,294	13			18,994		12
13	21	Clerical and General Office	Resident Days	251,294	13			18,994		13
14	22	Employee Benefits & Payroll	Resident Days	251,294	13			18,994		14
15	23	Inservice Training & Education	Resident Days	251,294	13			18,994		15
16	24	Travel and Seminar	Resident Days	251,294	13			18,994		16
17	25	Other Admin. Staff Transport.	Resident Days	251,294	13			18,994		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	251,294	13			18,994		18
19	30	Depreciation	Resident Days	251,294	13	4,252		18,994	321	19
20	31	Amortization	Resident Days	251,294	13	120,699		18,994	9,123	20
21	32	Interest	Resident Days	251,294	13	152,300		18,994	11,512	21
22	33	Real Estate Taxes	Resident Days	251,294	13			18,994		22
23	34	Rent-Facility and Grounds	Resident Days	251,294	13			18,994		23
24	35	Rent-Equipment & Vehicles	Resident Days	251,294	13			18,994		24
25	TOTALS					\$ 355,027	\$		\$ 26,835	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	Wells Fargo		X	Mortgage	Varies	1/1/2015	\$ 892,857	\$ 794,643	12/31/34	Varies	\$ 41,084	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 892,857	\$ 794,643			\$ 41,084	9	
	B. Non-Facility Related*												
10								Interest Income Offset			(1,334)	10	
11								Home Office Allocation-PHN			296	11	
12								Home Office Allocation-PHCM			11,512	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ 10,474	14	
15	TOTALS (line 9+line14)						\$ 892,857	\$ 794,643			\$ 51,558	15	

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

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		
1. Real Estate Tax accrual used on 2015 report.	\$	<u>55,224</u>		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	<u>53,516</u>		2
3. Under or (over) accrual (line 2 minus line 1).	\$	<u>(1,708)</u>		3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<u>55,116</u>		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$			5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. Home Office Allocation 232 TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$			6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	<u>53,640</u>		7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:		2011 <u> 52,346 </u> 8 2012 <u> 51,937 </u> 9 2013 <u> 52,342 </u> 10 2014 <u> 53,615 </u> 11 2015 <u> 53,516 </u> 12		
Accrual based on prior year tax bill.				

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

FACILITY NAME Nokomis Rehab & Hlth Care C COUNTY Montgomery

FACILITY IDPH LICENSE NUMBER 0050641

CONTACT PERSON REGARDING THIS REPORT MIKE KOCHER

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

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

PLEASE NOTE: *Payment information from the Internet* or otherwise is **not considered acceptable tax bill documentation** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

A. Square Feet:

32,807

B. General Construction Type:

Exterior

Brick

Frame

Steel & Brick

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:

561,304

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

20

3. Current Period Amortization:

9,123

4. Dates Incurred:

2013-2014

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.					
	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	217,800	2007	\$ 60,000	1
2					2
3	TOTALS	217,800		\$ 60,000	3

HFS 3745 (N-4-99)

IL478-2471

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	92		2007	1970	1,200,000		25	48,000	\$ 48,000	\$ 456,000	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Water Heater		2008		10,490		10	1,050	1,050	7,875	9
10	Smoke Detector		2009		2,799		7	400	400	2,600	10
11	Carpet		2010		2,652		15	177	177	1,062	11
12	Roof Repair		2010		9,362		7	1,337	1,337	7,354	12
13	Roof Repair-Front Entry Area		2011		5,753		25	230	230	1,035	13
14	Roof Repair		2012		2,875		7	410	410	1,435	14
15	Sprinkler System Replacement		2013		114,950		25	4,598	4,598	16,093	15
16	Roof Replacement		2014		44,203		25	1,768	1,768	4,405	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	Building Booked					48,000			(48,000)		31
32	Building Improvement Booked					9,637			(9,637)		32
33											33
34	2016-Home Office Allocation-Building Improvements				8,386			201	201		34
35	2016-Home Office Allocation-Land Improvements				772			50	50		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

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			\$	\$		\$	\$		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)		\$ 1,402,242	\$ 57,637		\$ 58,221	\$ 584	\$ 497,859	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	\$ 226,361	\$ 11,719	\$ 22,635	\$ 10,916	5-10 yrs.	\$ 167,950	71
72	Current Year Purchases	3,532	505	253	(252)	7 yrs.	253	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			10,135	10,135			74
75	TOTALS	\$ 229,893	\$ 12,224	\$ 33,023	\$ 20,799		\$ 168,203	75

D. Vehicle Costs. (See instructions.)*									
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
76				\$	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$	\$	\$	\$		\$

E. Summary of Care-Related Assets					1	2
		Reference			Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)			\$	1,692,135
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	69,861
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	91,244
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	21,383
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	666,062

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)				
	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4
86		\$	\$	\$
87				
88	N/A			
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94	N/A	
95		\$

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____*

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

15. Is Movable equipment rental included in building rental? ☒ YES ☐ NO
16. Rental Amount for movable equipment: \$ 11,986 Description: See Attached Schedule 14A
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18	N/A				18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____
Ending _____

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

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

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

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

**Nokomis Rehab & Hlth Care C
0050641**

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	\$	9,152
Dishwasher		701
Laundry Equipment		30
Copier		1,285
Home Office Allocation		818
		<u>11,986</u>
		<u><u>11,986</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

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.

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	

(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.)

	Service	Schedule V Line & Column Reference	2	3	4		6	7	8	
			Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	4,162	\$ 62,426	\$	4,162	\$ 62,426	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,161	17,415		1,161	17,415	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		5,337	80,058	50	5,337	80,108	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				34,878		34,878	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	10,660	\$ 159,899	\$ 34,928	10,660	\$ 194,827	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (397,665)	\$ (397,665)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 50,313)	721,315	721,315	3
4	Supply Inventory (priced at Cost)	7,357	7,357	4
5	Short-Term Investments			5
6	Prepaid Insurance	27,063	27,063	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Employee Education Loans	495	495	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 358,565	\$ 358,565	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	60,000	60,000	13
14	Buildings, at Historical Cost	1,200,000	1,208,386	14
15	Leasehold Improvements, at Historical Cost	193,084	193,856	15
16	Equipment, at Historical Cost	229,893	229,893	16
17	Accumulated Depreciation (book methods)	(683,604)	(666,062)	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):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 999,373	\$ 1,026,073	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,357,938	\$ 1,384,638	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 383,564	\$ 383,564	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	41,223	41,223	30
31	Accrued Taxes Payable (excluding real estate taxes)	23,435	23,435	31
32	Accrued Real Estate Taxes(Sch.IX-B)	55,116	55,116	32
33	Accrued Interest Payable	3,503	3,503	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	19,621	19,621	36
37	Accrued Management Fees	13,151	13,151	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 539,613	\$ 539,613	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	794,643	794,643	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)	\$ 794,643	\$ 794,643	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,334,256	\$ 1,334,256	46
47	TOTAL EQUITY(page 18, line 24)	\$ 23,682	\$ 50,382	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,357,938	\$ 1,384,638	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (219,808)	1
2	Restatements (describe):		2
3	Rounding	(1)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (219,809)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	243,491	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)	\$ 243,491	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)	\$ 23,682	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Nokomis Rehab & Hlth Care C

0050641

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	\$ 2,571,701	1
2	Discounts and Allowances for all Levels	(122,513)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,449,188	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	296,171	6
7	Oxygen	1,073	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 297,244	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	2,109	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	57,206	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	5,124	20
21	Other Medical Services	13,191	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 77,630	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,334	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,334	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Transportation Revenue</u>	15,072	28
28a	<u>Miscellaneous Revenue</u>	150	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 15,222	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,840,618	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	577,495	31
32	Health Care	1,161,850	32
33	General Administration	473,051	33
	B. Capital Expense		
34	Ownership	175,521	34
	C. Ancillary Expense		
35	Special Cost Centers	51,287	35
36	Provider Participation Fee	157,923	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,597,127	40
41	Income before Income Taxes (line 30 minus line 40)**	243,491	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 243,491	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,435,331	44
45	Private Pay - Net Inpatient Revenue	735,951	45
46	Medicare - Net Inpatient Revenue	263,950	46
47	Other-(specify) <u>Insurance Net Inpatient Revenue</u>	13,956	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,449,188	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,080	2,080	\$ 63,906	\$ 30.72	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,243	2,251	51,220	22.75	3
4	Licensed Practical Nurses	13,263	13,523	253,478	18.74	4
5	CNAs & Orderlies	37,951	38,597	404,907	10.49	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,820	1,871	22,482	12.02	9
10	Activity Assistants					10
11	Social Service Workers	2,063	2,169	35,604	16.41	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	27,649	13.29	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,341	11,498	102,035	8.87	15
16	Dishwashers					16
17	Maintenance Workers	2,080	2,080	38,674	18.59	17
18	Housekeepers	7,260	7,639	77,089	10.09	18
19	Laundry	4,951	5,235	49,927	9.54	19
20	Administrator	2,080	2,080	61,162	29.40	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,909	2,049	30,439	14.86	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care <u>CPC</u>	1,981	2,075	49,045	23.64	32
33	Other(specify) <u>Transportation</u>	1,911	1,975	21,778	11.03	33
34	TOTAL (lines 1 - 33)	95,013	97,202	\$ 1,289,395 *	\$ 13.27	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	14,250	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,196	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	8	241	L10, C3	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	8	\$ 18,687		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.

STATE OF ILLINOIS

Facility Name & ID Number

Nokomis Rehab & Hlth Care C

0050641

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Elvia Hopley	Administrator	0	\$ 5,445
Robby Jones	Administrator	0	55,717
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 61,162

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	\$ 216,400
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	\$ 216,400

C. Professional Services

Vendor/Payee	Type	Amount
Consolidated Communications	Computer Services	\$ 1,153
E-Health Data Solutions	Computer Services	3,043
Honkamp Krueger & Co.	Accounting Fees	2,308
ProTitle USA	Legal Fees	88
Dominick Valente	Legal Fees	1,560
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 8,151

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 34,527
Unemployment Compensation Insurance	26,514
FICA Taxes	93,730
Employee Health Insurance	3,742
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	539
Home Office Allocation	25,433
TOTAL (agree to Schedule V, line 22, col.8)	\$ 184,486

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$ 3,980
Advertising: Employee Recruitment	33
Health Care Worker Background Check (Indicate # of checks performed 22)	114
Patient Background Checks	
Miscellaneous Licenses & Permits	443
Miscellaneous Dues & Subscriptions	5,274
Home Office Allocation	415
Less: Public Relations Expense	(40)
Non-allowable advertising	()
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 10,219

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	
Home Office Allocation	42
Entertainment Expense	()
TOTAL (agree to Sch. V, line 24, col. 8)	\$ 42

* Attach copy of IMRF notifications

**See instructions.

Nokomis Rehab & Hlth Care C
0050641
Period Beginning1/1/2016
Period End12/31/2016

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		8,151
Home Office Allocation		
Lucie, Scalf, and Bougher	Legal	44
Miscellaneous	Legal	17
Miller Hall and Triggs	Legal	77
Healthcare Resources International	Legal	920
Hunziker Law	Legal	91
Lexis Nexis	Legal	8
Wells Fargo	Legal	421
CliftonLarson Allen	Accountants	398
Ginoli & Co.	Accountants	5,123
Wells Fargo	Accountants	1,098
Miscellaneous	Computer Services	50
Change Healthcare	Computer Services	7
PTC Select	Computer Services	4
Advanced Answers on Demand	Computer Services	3,498
Stratus Networks	Computer Services	356
Kemper Technology	Computer Services	234
AT&T	Computer Services	5
Ability Network	Computer Services	1,491
CIAN	Computer Services	178
Comcast	Computer Services	29
CCH	Computer Services	12
Charter Communications	Computer Services	35
Allscripts	Computer Services	520
ATS	Computer Services	235
Allpayer Exchange	Computer Services	12
Optimizer	Other Prof Fees	36
Ankura	Other Prof Fees	272
David Budde	Other Prof Fees	31
Bruner, Cooper, Zuck	Other Prof Fees	79
Marotta, Gund, Budd, Dzerda	Other Prof Fees	489
Professional Software and Services	Other Prof Fees	19
Hughes Valuation Services	Other Prof Fees	24
Alan Litwiller	Other Prof Fees	2

Total (agree to Schedule V, line 19, column 8)23,966

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No

(2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IHCA \$5234

(3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7 yrs.

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 13,287 Line 10

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

(8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A

(9) Are you presently operating under a sublease agreement? YES X NO

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 157,923
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

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

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,109

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 15,072
c. What percent of all travel expense relates to transportation of nurses and patients? 100
d. Have vehicle usage logs been maintained? Adequate records have been maintained.
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A

(17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli and Company

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. No
Attach invoices and a summary of services for all architect and appraisal fees

RECONCILIATION REPORT			Nokomis Rehab & Hlth		11:21 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	-49,116	equal to	-49,116	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	51,558	equal to	51,558	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	53,640	equal to	53,640	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	9,123	equal to	9,123	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	91,244	equal to	91,244	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	11,986	equal to	11,986	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	159,949	equal to	159,949	0	O.K.	Pg16 Z12+Z14..	N/A,B	1-4,40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv.- Supplies	34,928	equal to	34,928	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	577,495	equal to	577,495	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	1,161,850	equal to	1,161,850	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	473,051	equal to	473,051	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	175,521	equal to	175,521	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	51,287	equal to	51,287	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..,H24+I	N/A	38to41+43	4
Income Stat. Prov. Partic.	157,923	equal to	157,923	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	822,556	equal to	822,556	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	44,260	equal to	44,260	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	35,604	equal to	35,604	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	129,684	equal to	129,684	0	O.K.	Pg20 K22..,K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	38,674	equal to	38,674	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	77,089	equal to	77,089	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	49,927	equal to	49,927	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	61,162	equal to	61,162	0	O.K.	Pg20 K30..,K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	30,439	equal to	30,439	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	1,289,395	equal to	1,228,233	61,162	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	14,250	< or = to	14,250	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	4,437	< or = to	4,503	-66	O.K.	Pg20 X14..,X16+	B. & C.	7to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to	116	-116	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.	61,162	equal to	61,162	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	216,400	equal to	216,400	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	8,151	equal to	8,151	0	FAILED	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	184,486	equal to	184,486	0	FAILED	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	10,219	equal to	10,219	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	42	equal to	42	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	157,923	equal to	157,923	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	1,207	equal to	1,289	-82	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	-24,999	equal to	-24,999	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4I	B.	14	8
Total loan balance	794,643	equal to	794,643	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	55,116	equal to	55,116	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	60,000	equal to	60,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	1,402,242	equal to	1,402,242	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	229,893	equal to	229,893	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	666,062	equal to	666,062	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	23,682	equal to	23,682	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	243,491	equal to	243,491	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	1,357,938	equal to	1,357,938	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	129,684	11,052	0	140,736	0	140,736	3,902	144,638
2. Food Purchase	0	138,070	0	138,070	0	138,070	-2,038	136,032
3. Housekeeping	77,089	14,110	0	91,199	0	91,199	68	91,267
4. Laundry	49,927	11,933	0	61,860	0	61,860	0	61,860
5. Heat and Other Utilities	0	0	79,798	79,798	0	79,798	227	80,025
6. Maintenance	38,674	9,106	18,052	65,832	0	65,832	2,130	67,962
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	295,374	184,271	97,850	577,495	0	577,495	4,289	581,784
9. Medical Director	0	0	14,250	14,250	0	14,250	0	14,250
10. Nursing & Medical Records	822,556	80,501	4,503	907,560	0	907,560	36	907,596
10a. Therapy	0	50	159,899	159,949	0	159,949	0	159,949
11. Activities	44,260	97	116	44,473	0	44,473	-15,072	29,401
12. Social Services	35,604	14	0	35,618	0	35,618	0	35,618
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	902,420	80,662	178,768	1,161,850	0	1,161,850	-15,036	#####
17. Administrative	0	0	216,400	216,400	0	216,400	-155,238	61,162
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	8,151	8,151	0	8,151	15,815	23,966
20. Fees, Subscriptions & Promotion	0	0	9,844	9,844	0	9,844	375	10,219
21. Clerical & General Office	30,439	2,724	9,154	42,317	0	42,317	45,414	87,731
22. Employee Benefits & Payroll	0	0	159,053	159,053	0	159,053	25,433	184,486
23. Inservice Training & Education	0	0	0	0	0	0	87	87
24. Travel and Seminar	0	0	0	0	0	0	42	42
25. Other Admin. Staff Trans	0	0	8,422	8,422	0	8,422	3,578	12,000
26. Insurance-Prop.Liab.Malpractice	0	0	28,864	28,864	0	28,864	504	29,368
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	30,439	2,724	439,888	473,051	0	473,051	-63,990	409,061
29. Total General Administrative	1,228,233	267,657	716,506	2,212,396	0	2,212,396	-74,737	#####
30. Depreciation	0	0	69,861	69,861	0	69,861	21,383	91,244
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	9,123	9,123
32. Interest	0	0	41,084	41,084	0	41,084	10,474	51,558
33. Real Estate	0	0	53,408	53,408	0	53,408	232	53,640
34. Rent - Facility & Grounds	0	0	0	0	0	0	0	0
35. Rent - Equipment & Vehicles	0	0	11,168	11,168	0	11,168	818	11,986
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	175,521	175,521	0	175,521	42,030	217,551
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	34,878	0	34,878	0	34,878	0	34,878
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	157,923	157,923	0	157,923	0	157,923
43. Other (specify):*	0	176	16,233	16,409	0	16,409	-16,409	0
44. Total Special Cost Ce	0	35,054	174,156	209,210	0	209,210	-16,409	192,801
45. Grand Total	1,228,233	302,711	1,066,183	2,597,127	0	2,597,127	-49,116	#####

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	-397,665	-397,665
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	721,315	721,315
4. Supply Inventory	7,357	7,357
5. Short-Term Investments	0	0
6. Prepaid Insurance	27,063	27,063
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	495	495
10. Total current assets	358,565	358,565
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	60,000	60,000
14. Buildings, at Historical Cost	1,200,000	1,208,386
15. Leasehold Improvements, Historical Cost	193,084	193,856
16. Equipment, at Historical Cost	229,893	229,893
17. Accumulated Depreciation (book methods)	-683,604	-666,062
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	0
24. Total Long-Term Assets	999,373	1,026,073
25. Total Assets	1,357,938	1,384,638
CURRENT LIABILITIES		
26. Accounts Payable	383,564	383,564
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	41,223	41,223
31. Accrued Taxes Payable	23,435	23,435
32. Accrued Real Estate Taxes	55,116	55,116
33. Accrued Interest Payable	3,503	3,503
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	19,621	19,621
37. Other Current Liabilities (specify):	13,151	13,151
38. Total Current Liabilities	539,613	539,613
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	794,643	794,643
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	794,643	794,643
46.Total Liabilities	1,334,256	1,334,256
47.Total Equity	23,682	50,382
48.Total Liabilities and Equity	1,357,938	1,384,638

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	2,571,701
2. Discounts and Allowances for all Levels	-122,513
Subtotal - Inpatient Care	2,449,188
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	296,171
7. Oxygen	1,073
Subtotal - Ancillary Revenue	297,244
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	2,109
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	57,206
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiology and X-Ray	5,124
21. Other Medical Services	13,191
22. Laundry	0
Subtotal - Other Operating Revenue	77,630
24. Contributions	0
25. Interest and Other Investments Income	1,334
Subtotal - Non-Operating Revenue	1,334
27. Other Revenue (specify):	15,072
28. Other Revenue (specify):	150
Subtotal - Other Revenue	15,222
30. Total Revenue	2,840,618
31. General Services	576,863
32. Health Care	1,153,005
33. General Administration	493,243
34. Ownership	173,824
35. Special Cost Centers	59,411
35. Provider Participation Fee	160,947
37. Other	0
40. Total Expenses	2,617,293
41. Income Before Income Taxes	223,325
42. Income Taxes	0
43. Net Income or Loss for the Year	223,325