

		FOR BHF USE					

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

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

I. IDPH License ID Number: 0050849

Facility Name: Roseville Rehab & Hlth Care

Address: 145 S Chamberlain St Roseville 61473
Number City Zip Code

County: Warren

Telephone Number: (309) 426-2134 Fax # (309) 426-2445

HFS ID Number:

Date of Initial License for Current Owners: 4/1/2010

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 Roseville Rehab & Hlth Care

0050849 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 <u>N/A</u>					
	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>99</u>	Skilled (SNF)	<u>99</u>	<u>36,135</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>99</u>	TOTALS	<u>99</u>	<u>36,135</u>	7

B. Census-For the entire report period.						
	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>14,329</u>	<u>5,907</u>	<u>1,543</u>	<u>21,779</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>14,329</u>	<u>5,907</u>	<u>1,543</u>	<u>21,779</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 60.27%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☒ NO ☐

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

I. On what date did you start providing long term care at this location?
Date started 4/1/2010

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 4/1/2010 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 99 and days of care provided 1,370

Medicare Intermediary Cahaba

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/2016 Fiscal Year: 12/31/2016
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Roseville Rehab & Hlth Care # 0050849 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	138,227	11,539		149,766		149,766	4,474	154,240			1
2	Food Purchase		141,216		141,216		141,216	(5,058)	136,158			2
3	Housekeeping	108,894	18,992		127,886		127,886	78	127,964			3
4	Laundry	39,049	13,271		52,320		52,320		52,320			4
5	Heat and Other Utilities			82,302	82,302		82,302	261	82,563			5
6	Maintenance	45,907	12,160	17,903	75,970		75,970	2,395	78,365			6
7	Other (specify):* <u>Home Office Ben. Allocation</u>											7
8	TOTAL General Services	332,077	197,178	100,205	629,460		629,460	2,150	631,610			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	937,524	67,625	59,885	1,065,034		1,065,034	(277)	1,064,757			10
10a	Therapy			239,953	239,953		239,953		239,953			10a
11	Activities	68,129	389	203	68,721		68,721	(22,096)	46,625			11
12	Social Services	25,092			25,092		25,092		25,092			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* <u>Home Office Ben. Allocation</u>											15
16	TOTAL Health Care and Programs	1,030,745	68,014	312,041	1,410,800		1,410,800	(22,373)	1,388,427			16
	C. General Administration											
17	Administrative			272,300	272,300		272,300	(199,950)	72,350			17
18	Directors Fees											18
19	Professional Services			38,505	38,505		38,505	11,393	49,898			19
20	Dues, Fees, Subscriptions & Promotions			3,769	3,769		3,769	476	4,245			20
21	Clerical & General Office Expenses	28,898	4,689	25,345	58,932		58,932	52,113	111,045			21
22	Employee Benefits & Payroll Taxes			161,917	161,917		161,917	29,162	191,079			22
23	Inservice Training & Education							100	100			23
24	Travel and Seminar							49	49			24
25	Other Admin. Staff Transportation			11,461	11,461		11,461	4,103	15,564			25
26	Insurance-Prop.Liab.Malpractice			1,879	1,879		1,879	43,701	45,580			26
27	Other (specify):* <u>Home Office Ben. Allocation</u>											27
28	TOTAL General Administration	28,898	4,689	515,176	548,763		548,763	(58,853)	489,910			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,391,720	269,881	927,422	2,589,023		2,589,023	(79,076)	2,509,947			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			21,347	21,347		21,347	193,956	215,303			30
31	Amortization of Pre-Op. & Org.							993	993			31
32	Interest			1,393	1,393		1,393	164,212	165,605			32
33	Real Estate Taxes							132,677	132,677			33
34	Rent-Facility & Grounds			577,337	577,337		577,337	(577,337)				34
35	Rent-Equipment & Vehicles			14,359	14,359		14,359	938	15,297			35
36	Other (specify):*											36
37	TOTAL Ownership			614,436	614,436		614,436	(84,561)	529,875			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		38,393		38,393		38,393		38,393			39
40	Barber and Beauty Shops	2,898		90	2,988		2,988	(90)	2,898			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			177,321	177,321		177,321		177,321			42
43	Other (specify):*	33,781	374	79,513	113,668		113,668	(113,668)				43
44	TOTAL Special Cost Centers	36,679	38,767	256,924	332,370		332,370	(113,758)	218,612			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,428,399	308,648	1,798,782	3,535,829		3,535,829	(277,395)	3,258,434			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	(5,139)	2		4
5	Telephone, TV & Radio in Resident Rooms	(11,305)	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	(24,475)	30		9
10	Interest and Other Investment Income	(5)			10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(314)	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	(63,080)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,293)	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	(66,058)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (172,669)		\$	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)	(104,726)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (104,726)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (277,395)		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	\$ (3,396)	43	1
2	X-Rays-Part A	(3,199)	43	2
3	Resident Flowers	(360)	43	3
4	Offset Miscellaneous Office Supplies Revenue	(40)	21	4
5	Offset Transportation Revenue	(22,096)	11	5
6	Offset Miscellaneous Nursing Supplies Revenue	(410)	10	6
7	Special Events	(791)	43	7
8	Offset Barber and Beauty Revenue	(90)	40	8
9	Disallowed Marketing Expense	(33,781)	43	9
10	Pet Expense	(1,128)	43	10
11	Offset Cable TV Revenue	(720)	43	11
12	Disallowed Equipment Rental Revenue	(47)	6	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	(66,058)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Roseville Rehab & Hlth Care# 0050849

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	4,474	0	0	0	0	0	0	0	0	0	4,474	1
2	Food Purchase	(5,139)	81	0	0	0	0	0	0	0	0	0	(5,058)	2
3	Housekeeping	0	78	0	0	0	0	0	0	0	0	0	78	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	261	0	0	0	0	0	0	0	0	0	261	5
6	Maintenance	(47)	2,442	0	0	0	0	0	0	0	0	0	2,395	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(5,186)	7,336	0	0	0	0	0	0	0	0	0	2,150	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	(410)	133	0	0	0	0	0	0	0	0	0	(277)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(22,096)	0	0	0	0	0	0	0	0	0	0	(22,096)	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	(22,506)	133	0	0	0	0	0	0	0	0	0	(22,373)	16
	C. General Administration													
17	Administrative	0	(199,950)	0	0	0	0	0	0	0	0	0	(199,950)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	11,393	0	0	0	0	0	0	0	0	0	11,393	19
20	Fees, Subscriptions & Promotions	0	0	476	0	0	0	0	0	0	0	0	476	20
21	Clerical & General Office Expenses	(40)	0	52,153	6,699	0	0	0	0	0	0	0	58,812	21
22	Employee Benefits & Payroll Taxes	0	0	29,162	0	0	0	0	0	0	0	0	29,162	22
23	Inservice Training & Education	0	0	100	0	0	0	0	0	0	0	0	100	23
24	Travel and Seminar	0	0	49	0	0	0	0	0	0	0	0	49	24
25	Other Admin. Staff Transportation	0	0	4,103	0	0	0	0	0	0	0	0	4,103	25
26	Insurance-Prop.Liab.Malpractice	0	0	578	43,123	0	0	0	0	0	0	0	43,701	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(40)	(188,557)	86,621	49,822	0	0	0	0	0	0	0	(52,154)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(27,732)	(181,088)	86,621	49,822	0	0	0	0	0	0	0	(72,377)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Roseville Rehab & Hlth Care # 0050849 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	(24,475)	0	11,541	206,890	0	0	0	0	0	0	0	193,956	30
31	Amortization of Pre-Op. & Org.	0	0	0	993	0	0	0	0	0	0	0	993	31
32	Interest	0	0	339	163,878	0	0	0	0	0	0	0	164,217	32
33	Real Estate Taxes	0	0	266	132,411	0	0	0	0	0	0	0	132,677	33
34	Rent-Facility & Grounds	0	0	0	(577,337)	0	0	0	0	0	0	0	(577,337)	34
35	Rent-Equipment & Vehicles	0	0	938	0	0	0	0	0	0	0	0	938	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(24,475)	0	13,084	(73,165)	0	0	0	0	0	0	0	(84,556)	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	(90)	0	0	0	0	0	0	0	0	0	0	(90)	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):*	(120,367)	0	0	0	0	0	0	0	0	0	0	(120,367)	43
44	TOTAL Special Cost Centers	(120,457)	0	0	0	0	0	0	0	0	0	0	(120,457)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(172,664)	(181,088)	99,705	(23,343)	0	0	0	0	0	0	0	(277,390)	45

VII. RELATED PARTIES

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

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

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	<u>Dietary</u>	\$	<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>\$ 4,474</u>	<u>\$ 4,474</u>	1
2	V	2	<u>Food</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>81</u>	<u>81</u>	2
3	V	3	<u>Housekeeping</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>78</u>	<u>78</u>	3
4	V	5	<u>Utilities</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>261</u>	<u>261</u>	4
5	V	6	<u>Maintenance</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>2,442</u>	<u>2,442</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>133</u>	<u>133</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>272,300</u>	<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>72,350</u>	<u>(199,950)</u>	11
12	V	19	<u>Professional Services</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>11,393</u>	<u>11,393</u>	12
13	V								13
14	Total			\$ 272,300			\$ 91,212	\$ * (181,088)	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.

☒ X

 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%	\$ 476	\$ 476	15
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	52,153	52,153	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	29,162	29,162	17
18	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	100	100	18
19	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	49	49	19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	4,103	4,103	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	578	578	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%	11,541	11,541	23
24	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	339	339	24
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	266	266	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	938	938	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			\$			\$ 99,705	\$ * 99,705	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.

☒ X

 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:	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	21 Clerical and General Office		Petersen Health Care-Roseville, LLC	100.00%	6,699	\$	6,699
16	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care-Roseville, LLC	100.00%	43,123		43,123
17	V	30 Depreciation		Petersen Health Care-Roseville, LLC	100.00%	206,890		206,890
18	V	31 Amortization		Petersen Health Care-Roseville, LLC	100.00%	993		993
19	V	32 Interest	161	Petersen Health Care-Roseville, LLC	100.00%	164,039		163,878
20	V	33 Real Estate Taxes		Petersen Health Care-Roseville, LLC	100.00%	132,411		132,411
21	V	34 Rent-Facility and Grounds	577,337	Petersen Health Care-Roseville, LLC	100.00%			(577,337)
22	V							
23	V							
24	V							
25	V							
26	V							
27	V							
28	V							
29	V							
30	V							
31	V							
32	V							
33	V							
34	V							
35	V							
36	V							
37	V							
38	V							
39	Total		\$ 577,498			\$ 554,155	\$ *	(23,343)

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

Facility Name & ID Number

Roseville Rehab & Hlth Care

0050849

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

Roseville Rehab & Hlth Care

0050849

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

Roseville Rehab & Hlth Care

0050849

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 Roseville Rehab & Hlth Care # 0050849 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 Roseville Rehab & Hlth Care# 0050849

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	21,779	\$ 4,474	1
2	2	Food	Resident Days	75	5,673	0	21,779	81	2
3	3	Housekeeping	Resident Days	75	5,456	2,897	21,779	78	3
4	5	Utilities	Resident Days	75	18,209	0	21,779	261	4
5	6	Maintenance	Resident Days	75	170,632	137,057	21,779	2,442	5
6	7	Mgmt. Allocation of Benefits	Resident Days	75	0	0	21,779	0	6
7	9	Medical Director	Resident Days	75	0	0	21,779	0	7
8	10	Nursing and Medical Records	Resident Days	75	9,261	1,782,521	21,779	133	8
9	10A	Therapy	Resident Days	75	0	0	21,779	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	75	0	0	21,779	0	10
11	17	Administrative	Resident Days	75	4,899,467	5,473,961	21,779	72,350	11
12	19	Professional Services	Resident Days	75	795,918	0	21,779	11,393	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	75	33,278	0	21,779	476	13
14	21	Clerical and General Office	Resident Days	75	3,643,535	3,756,135	21,779	52,153	14
15	22	Employee Benefits and Payroll Ta	Resident Days	75	2,037,314	0	21,779	29,162	15
16	23	Inservice Training & Education	Resident Days	75	6,986	0	21,779	100	16
17	24	Travel and Seminar	Resident Days	75	3,389	0	21,779	49	17
18	25	Other Admin. Staff Transport.	Resident Days	75	286,637	0	21,779	4,103	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	75	40,378	0	21,779	578	19
20	27	Mgmt. Allocation of Benefits	Resident Days	75	0	0	21,779	0	20
21	30	Depreciation	Resident Days	75	806,271	0	21,779	11,541	21
22	32	Interest	Resident Days	75	23,686	0	21,779	339	22
23	33	Real Estate Taxes	Resident Days	75	18,560	0	21,779	266	23
24	35	Rent-Equipment & Vehicles	Resident Days	75	65,550	0	21,779	938	24
25	TOTALS				\$ 13,182,740	\$ 11,510,481		\$ 190,917	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	Berkadia		X	Mortgage	\$44,073.00	4/1/10	\$ 3,998,669	\$ 3,129,851	3/31/39	0.0614	\$ 164,039	1	
2	Ford Credit		X	Vehicle	\$752.57	3/25/14	38,605	18,140	3/24/19	0.0624	1,393	2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$44,825.57		\$ 4,037,274	\$ 3,147,991			\$ 165,432	9	
	B. Non-Facility Related*												
10								Interest Income Offset			(166)	10	
11								Home Office Allocation-PHCM			339	11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ 173	14	
15	TOTALS (line 9+line14)						\$ 4,037,274	\$ 3,147,991			\$ 165,605	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 Roseville Rehab & Hlth Care COUNTY Warren

FACILITY IDPH LICENSE NUMBER 0050849

CONTACT PERSON REGARDING THIS REPORT MIKE KOCHER

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

A. **Summary of Real Estate Tax Cost**

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

(A)	(B)	(C)	(D)
			<u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
			<u>Nursing Home</u>
1. <u>07-050-089-10</u>	<u>Land</u>	\$ <u>528.50</u>	\$ <u>528.50</u>
2. <u>07-050-090-00</u>	<u>Nursing Facility</u>	\$ <u>121,455.26</u>	\$ <u>121,455.26</u>
3. <u>07-050-107-00</u>	<u>Land</u>	\$ <u>58.98</u>	\$ <u>58.98</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>122,042.74</u></u>	\$ <u><u>122,042.74</u></u>

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

A. Square Feet:

29,817

B. General Construction Type:

Exterior Brick

Frame Block

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:

21,596

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

21

3. Current Period Amortization:

993

4. Dates Incurred:

2013

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		2010	\$ 400,000	1
2					2
3	TOTALS			\$ 400,000	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	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	99		2010		\$ 2,998,669	\$	25	\$ 119,947	\$ 119,947	\$ 659,708
5										
6										
7										
8										
	Improvement Type**									
9	Water Heater		2013		5,776		7	822	822	2,055
10	Carpeting for Activity Room and Main Hallway		2013		10,088		15	672	672	1,680
11	Water Heater		2014		3,228		7	461	461	768
12	Shower Room Installation		2016		17,484		15	583	583	583
13										
14										
15										
16										
17										
18										
19										
20										
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29										
30										
31	Building Booked					119,947			(119,947)	
32	Building Improvement Booked					2,541			(2,541)	
33										
34	2016-Home Office Allocation-Building Improvements				9,615			231	231	
35	2016-Home Office Allocation-Land Improvements				885			57	57	
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)		\$ 3,045,745	\$ 122,488		\$ 122,773	\$ 285	\$ 664,794	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	\$611,775	\$87,397	\$61,178	\$(26,219)	5-10 yrs.	\$394,443	71
72	Current Year Purchases	29,602	2,483	4,229	1,746	7 yrs.	4,229	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			11,253	11,253			74
75	TOTALS	\$641,377	\$89,880	\$76,660	\$(13,220)		\$398,672	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	Van	2012	\$38,000	\$7,600	\$7,600		5 yrs.	\$34,833	76
77	Facility	Ford E250	2014	41,349	8,270	8,270		5 yrs.	20,675	77
78										78
79										79
80	TOTALS			\$79,349	\$15,870	\$15,870			\$55,508	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$4,166,471	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$228,238	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$215,303	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(12,935)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$1,118,974	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: 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. YESNO

		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: YESNO
- Terms:
- *

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

15. Is Movable equipment rental included in building rental? YESNO
16. Rental Amount for movable equipment: \$15,297Description: 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.	/2017	\$
13.	/2018	\$
14.	/2019	\$

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

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

Roseville Rehab & Hlth Care
0050849

Period Beginning 1/1/2016
Period End 12/31/2016

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$ 12,346
Copier	2,013
Home Office Allocation	938
	15,297

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

D. NUMBER OF CNAs TRAINED

		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.

\$

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

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

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

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

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

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

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

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)										
		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	3,914	\$ 58,715	\$	3,914	\$ 58,715	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		341	5,122		341	5,122	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		11,741	176,116		11,741	176,116	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				38,393		38,393	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			\$	15,996	\$ 239,953	\$ 38,393	15,996	\$ 278,346	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	\$ 31,536	\$ 31,736	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 83,245)	894,685	894,685	3
4	Supply Inventory (priced at Cost)			4
5	Short-Term Investments			5
6	Prepaid Insurance	26,120	30,075	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Prepaid Expenses	9,595	9,595	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 961,936	\$ 966,091	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		400,000	13
14	Buildings, at Historical Cost		3,008,284	14
15	Leasehold Improvements, at Historical Cost	19,092	37,461	15
16	Equipment, at Historical Cost	111,673	720,726	16
17	Accumulated Depreciation (book methods)	(71,683)	(1,118,974)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		21,596	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(6,703)	20
21	Restricted Funds		774,525	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 59,082	\$ 3,836,915	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,021,018	\$ 4,803,006	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 581,938	\$ 604,317	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	45,066	45,066	30
31	Accrued Taxes Payable (excluding real estate taxes)	32,424	32,424	31
32	Accrued Real Estate Taxes(Sch.IX-B)		125,700	32
33	Accrued Interest Payable		9,781	33
34	Deferred Compensation	2,032	2,032	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	259,188	259,188	36
37	Accrued Management Fees	1,455,036	1,455,036	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,375,684	\$ 2,533,544	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	18,140	18,140	39
40	Mortgage Payable		3,129,851	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Intercompany Loans	100,825	100,825	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 118,965	\$ 3,248,816	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,494,649	\$ 5,782,360	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,473,631)	\$ (979,354)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,021,018	\$ 4,803,006	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,359,440)	1
2	Restatements (describe):		2
3	Prior Period Adjustments Made After Cost Report Was Filed	(30,001)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,389,441)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(84,190)	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)	\$ (84,190)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,473,631)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Roseville Rehab & Hlth Care

0050849

Report Period Beginning: 1/1/2016

Ending: 12/31/2016

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

1			
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,122,934	1
2	Discounts and Allowances for all Levels	(208,927)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,914,007	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	408,365	6
7	Oxygen	527	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 408,892	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	872	13
14	Non-Patient Meals	5,139	14
15	Telephone, Television and Radio	720	15
16	Rental of Facility Space		16
17	Sale of Drugs	72,474	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	10,169	20
21	Other Medical Services	16,768	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 106,142	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Transportation Revenue</u>	22,096	28
28a	<u>Miscellaneous Revenue</u>	497	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 22,593	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,451,639	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	629,460	31
32	Health Care	1,410,800	32
33	General Administration	548,763	33
	B. Capital Expense		
34	Ownership	614,436	34
	C. Ancillary Expense		
35	Special Cost Centers	155,049	35
36	Provider Participation Fee	177,321	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,535,829	40
41	Income before Income Taxes (line 30 minus line 40)**	(84,190)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (84,190)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,718,650	44
45	Private Pay - Net Inpatient Revenue	920,506	45
46	Medicare - Net Inpatient Revenue	247,846	46
47	Other-(specify) <u>Insurance -Net Patient Revenue</u>	27,005	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,914,007	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.

Facility Name & ID Number Roseville Rehab & Hlth Care# 0050849

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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	2,059	2,095	\$ 55,208	\$ 26.35	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,486	6,668	179,778	26.96	3
4	Licensed Practical Nurses	8,891	9,262	177,021	19.11	4
5	CNAs & Orderlies	38,835	40,275	462,784	11.49	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,246	1,482	18,687	12.61	9
10	Activity Assistants	2,128	2,162	22,920	10.60	10
11	Social Service Workers	1,908	1,931	25,092	12.99	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	28,135	13.53	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,407	11,646	110,092	9.45	15
16	Dishwashers					16
17	Maintenance Workers	1,806	2,014	45,907	22.79	17
18	Housekeepers	9,849	10,138	108,894	10.74	18
19	Laundry	1,872	2,032	39,049	19.22	19
20	Administrator	2,080	2,080	72,350	34.78	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,057	2,057	28,898	14.05	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	548	550	13,032	23.69	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>See PG20A</u>	5,787	5,899	112,902	19.14	33
34	TOTAL (lines 1 - 33)	99,039	102,371	\$ 1,500,749 *	\$ 14.66	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	12,000	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,830	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 16,830		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	63	2,736	L10, C3	51
52	Certified Nurse Assistants/Aides	1,611	51,702	L10, C3	52
53	TOTAL (lines 50 - 52)	1,674	\$ 54,438		53

Roseville Rehab & Hlth Care
0050849
Period Beginning 1/1/2016
Period End 12/31/2016

Schedule 20A

XVIII. Staffing and Salary Costs

			Reporting Period	
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	1,870	1,870	49,701	26.58
Barber Shop	161	161	2,898	18.00
Transportation	1,785	1,785	26,522	14.86
Marketing	1,971	2,083	33,781	16.22
TOTAL	5,787	5,899	112,902	

STATE OF ILLINOIS

Page 21

Facility Name & ID Number

Roseville Rehab & Hlth Care

0050849

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	
Ethel Logue		Administrator	0	\$ 72,350	Workers' Compensation Insurance		\$ 33,502	IDPH License Fee		\$	
					Unemployment Compensation Insurance		15,351	Advertising: Employee Recruitment		506	
					FICA Taxes		107,846	Health Care Worker Background Check			
					Employee Health Insurance		4,277	(Indicate # of checks performed 90)		1,181	
					Employee Meals			Patient Background Checks		42 556	
					Illinois Municipal Retirement Fund (IMRF)*			Miscellaneous Licenses & Permits		526	
					Employee Relations		941	Miscellaneous Dues & Subscriptions		1,000	
					Home Office Allocation		29,162	Home Office Allocation		476	
TOTAL (agree to Schedule V, line 17, col. 1)											
(List each licensed administrator separately.)				\$ 72,350							
B. Administrative - Other											
Description			Amount					Less: Public Relations Expense		()	
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 272,300					Non-allowable advertising		()	
								Yellow page advertising		()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 272,300	TOTAL (agree to Schedule V, line 22, col.8)		\$ 191,079	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 4,245		
(Attach a copy of any management service agreement)											
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**			
Vendor/Payee		Type	Amount	Description		Line #	Amount	Description		Amount	
Frontier		Computer Services	\$ 1,080					Out-of-State Travel		\$	
Ginoli & Company		Accounting Services	7,460								
Warren County Clerk		Filing Fees	20	N/A							
Mediacom		Computer Services	1,661					In-State Travel			
Honkamp Kruger		Accounting Services	910								
E-Health Services		Computer Services	3,063								
Sorling Northrup		Legal Fees-Crain Case	18,870								
IL Sec. of State		Legal Fees	250					Seminar Expense			
Berkadia		Legal Fees	99								
Wells Fargo		Legal Fees	43					Home Office Allocation		49	
Pen Air Federal Credit Union		Legal Fees	49								
Marotta, Gund, Budd, & Dzera		Consulting fees	5,000					Entertainment Expense		()	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			\$	(agree to Sch. V, line 24, col. 8)			
(For legal fee disclosure, see page 39 of instructions)			\$ 38,505					TOTAL		\$ 49	

* Attach copy of IMRF notifications

**See instructions.

Roseville Rehab & Hlth Care
0050849

Period Beginning

1/1/2016

Period End

12/31/2016

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		38,505

Home Office Allocation

Lucie, Scalf, and Bougher	Legal	51
Miscellaneous	Legal	18
Miller Hall and Triggs	Legal	88
Healthcare Resources International	Legal	439
Hunziker Law	Legal	105
Lexis Nexis	Legal	9
CliftonLarson Allen	Accountants	457
Ginoli & Co.	Accountants	1,491
Miscellaneous	Computer Services	58
Change Healthcare	Computer Services	9
PTC Select	Computer Services	5
Advanced Answers on Demand	Computer Services	4,011
Stratus Networks	Computer Services	408
Kemper Technology	Computer Services	269
AT&T	Computer Services	6
Ability Network	Computer Services	1,710
CIAN	Computer Services	204
Comcast	Computer Services	33
CCH	Computer Services	13
Charter Communications	Computer Services	40
Allscripts	Computer Services	596
ATS	Computer Services	269
Allpayer Exchange	Computer Services	14
Optimizer	Other Prof Fees	41
Ankura	Other Prof Fees	311
David Budde	Other Prof Fees	35
Bruner, Cooper, Zuck	Other Prof Fees	91
Marotta, Gund, Budd, Dzerda	Other Prof Fees	560
Professional Software and Services	Other Prof Fees	22
Hughes Valuation Services	Other Prof Fees	28
Alan Litwiller	Other Prof Fees	2

Total (agree to Schedule V, line 19, column 8)	<u><u>49,898</u></u>
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**Roseville Rehabilitation & Health Care
0050849**

Period Beginning **1/1/2016**
Period End **12/31/2016**

Schedule 21B

XIX. SUPPORT SCHEDULE
Legal Fees

Home Office Allocation-PHC & PHCM

Lucie, Scaf, and Bougher	Legal	51
Miscellaneous	Legal	18
Miller Hall and Triggs	Legal	88
Healthcare Resources International	Legal	439
Hunziker Law	Legal	105
Lexis Nexis	Legal	9

Direct Facility Invoices

Sorling Northrup-Crain Case	1/8/2016	4,347
Illinois Secretary of State-Filing Fees	1/25/2016	250
Berkadia-Filing Fees	2/23/2016	37
Sorling Northrup-Crain Case	3/7/2016	1,733
Sorling Northrup-Crain Case	4/7/2016	5,031
Sorling Northrup-Crain Case	5/6/2016	2,820
Sorling Northrup-Crain Case	6/8/2016	5,434
Pen Air Federal Credit Union-Filing Fees	6/20/2016	49
Sorling Northrup-Crain Case	7/5/2016	115
Berkadia-Filing Fees	7/29/2016	62
Sorling Northrup-Crain Case	2/8/2016	800
Sorling Northrup-Crain Case	8/5/2016	255
Wells Fargo-Filing Fees	12/6/2016	43
Warren County Clerk-Filing Fees	5/22/2015	20

Total Legal Fees (agree to Schedule V, line 19, column	<u>21,706</u>
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XX. GENERAL INFORMATION:

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

No

(2) Are there any dues to nursing home associations included on the cost report?

Yes

If YES, give association name and amount. IHCA \$1000

(3) Did the nursing home make political contributions or payments to a political action organization?

No

If YES, have these costs been properly adjusted out of the cost report?

N/A

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

No

If YES, what is the capacity?

N/A

(5) Have you properly capitalized all major repairs and equipment purchases?

Yes

What was the average life used for new equipment added during this period?

7 yrs.

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

\$ 16,946

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.

\$ 177,321

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.

\$ 5,139

(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.

\$ 22,096

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.

Yes

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

RECONCILIATION REPORT			Roseville Rehab & Hlth		12:01 PM	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	-277,395	equal to	-277,395	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	165,605	equal to	165,605	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	132,677	equal to	132,677	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	993	equal to	993	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	215,303	equal to	215,303	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	15,297	equal to	15,297	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	239,953	equal to	239,953	0	O.K.	Pg16 Z12+Z14..	N/A,B	1-4,40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv.- Supplies	38,393	equal to	38,393	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	629,460	equal to	629,460	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	1,410,800	equal to	1,410,800	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	548,763	equal to	548,763	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	614,436	equal to	614,436	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	155,049	equal to	155,049	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..,H24+I	N/A	38to41+43	4
Income Stat. Prov. Partic.	177,321	equal to	177,321	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	937,524	equal to	937,524	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	68,129	equal to	68,129	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	25,092	equal to	25,092	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	138,227	equal to	138,227	0	O.K.	Pg20 K22..,K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	45,907	equal to	45,907	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	108,894	equal to	108,894	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	39,049	equal to	39,049	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	72,350	equal to	72,350	0	O.K.	Pg20 K30..,K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	28,898	equal to	28,898	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	1,500,749	equal to	1,428,399	72,350	FAILED	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	0	< or = to		#VALUE!	#VALUE!	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	12,000	< or = to	12,000	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	59,268	< or = to	59,885	-617	O.K.	Pg20 X14..,X16+	B. & C.	7to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to	203	-203	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.	72,350	equal to	72,350	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	272,300	equal to	272,300	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	38,505	equal to	38,505	0	FAILED	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	191,079	equal to	191,079	0	FAILED	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched. of dues..	4,245	equal to	4,245	0	FAILED	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	49	equal to	49	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	177,321	equal to	177,321	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	1,370	equal to	1,543	-173	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	-104,726	equal to	-104,726	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4I	B.	14	8
Total loan balance	3,147,991	equal to	3,147,991	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	125,700	equal to	125,700	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	400,000	equal to	400,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	3,045,745	equal to	3,045,745	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	720,726	equal to	720,726	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	1,118,974	equal to	1,118,974	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	-1,473,631	equal to	-1,473,631	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	-84,190	equal to	-84,190	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	1,021,018	equal to	1,021,018	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	138,227	11,539	-	149,766	0	149,766	4,474	154,240
2. Food Purchase	-	141,216	-	141,216	0	141,216	-5,058	136,158
3. Housekeeping	108,894	18,992	-	127,886	0	127,886	78	127,964
4. Laundry	39,049	13,271	-	52,320	0	52,320	0	52,320
5. Heat and Other Utilities	-	-	82,302	82,302	0	82,302	261	82,563
6. Maintenance	45,907	12,160	17,903	75,970	0	75,970	2,395	78,365
7. Other (specify)*	-	-	-	0	0	0	0	0
8. Total General Services	332,077	197,178	100,205	629,460	0	629,460	2,150	631,610
9. Medical Director	-	-	12,000	12,000	0	12,000	0	12,000
10. Nursing & Medical Records	937,524	67,625	59,885	1,065,034	0	1,065,034	-277	#####
10a. Therapy	-	-	239,953	239,953	0	239,953	0	239,953
11. Activities	68,129	389	203	68,721	0	68,721	-22,096	46,625
12. Social Services	25,092	-	-	25,092	0	25,092	0	25,092
13. Nurse Aide Training	-	-	-	0	0	0	0	0
14. Program Transportation	-	-	-	0	0	0	0	0
15. Other (specify)*	-	-	-	0	0	0	0	0
16. Total Health Care & Programs	#####	68,014	312,041	1,410,800	0	1,410,800	-22,373	#####
17. Administrative	-	-	272,300	272,300	0	272,300	-199,950	72,350
18. Directors Fees	-	-	-	0	0	0	0	0
19. Professional Services	-	-	38,505	38,505	0	38,505	11,393	49,898
20. Fees, Subscriptions & Promotion	-	-	3,769	3,769	0	3,769	476	4,245
21. Clerical & General Office	28,898	4,689	25,345	58,932	0	58,932	52,113	111,045
22. Employee Benefits & Payroll	-	-	161,917	161,917	0	161,917	29,162	191,079
23. Inservice Training & Education	-	-	-	0	0	0	100	100
24. Travel and Seminar	-	-	-	0	0	0	49	49
25. Other Admin. Staff Trans	-	-	11,461	11,461	0	11,461	4,103	15,564
26. Insurance-Prop.Liab.Malpractice	-	-	1,879	1,879	0	1,879	43,701	45,580
27. Other (specify)*	-	-	-	0	0	0	0	0
28. Total General Adminis	28,898	4,689	515,176	548,763	0	548,763	-58,853	489,910
29. Total General Administrative	#####	269,881	927,422	2,589,023	0	2,589,023	-79,076	#####
30. Depreciation	-	-	21,347	21,347	0	21,347	193,956	215,303
31. Amortization of Pre-Op. & Org.	-	-	-	0	0	0	993	993
32. Interest	-	-	1,393	1,393	0	1,393	164,212	165,605
33. Real Estate	-	-	-	0	0	0	132,677	132,677
34. Rent - Facility & Grounds	-	-	577,337	577,337	0	577,337	-577,337	0
35. Rent - Equipment & Vehicles	-	-	14,359	14,359	0	14,359	938	15,297
36. Other (specify):*	-	-	-	0	0	0	0	0
37. Total Ownership	-	-	614,436	614,436	0	614,436	-84,561	529,875
38. Medically Necessary T	-	-	-	0	0	0	0	0
39. Ancillary Service Cent	-	38,393	-	38,393	0	38,393	0	38,393
40. Barber and Beauty Shop	2,898	-	90	2,988	0	2,988	-90	2,898
41. Coffee and Gift Shops	-	-	-	0	0	0	0	0
42	-	-	177,321	177,321	0	177,321	0	177,321
43. Other (specify):*	33,781	374	79,513	113,668	0	113,668	-113,668	0
44. Total Special Cost Ce	36,679	38,767	256,924	332,370	0	332,370	-113,758	218,612
45. Grand Total	#####	308,648	#####	3,535,829	0	3,535,829	-277,395	#####

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	31,536	31,736
2. Cash - Patient Deposits	-	-
3. Accounts & Notes Recievable	894,685	894,685
4. Supply Inventory	-	-
5. Short-Term Investments	-	-
6. Prepaid Insurance	26,120	30,075
7. Other Prepaid Expenses	-	-
8. Accounts Receivable-Owner/Related Party	-	-
9. Other (specify):	9,595	9,595
10. Total current assets	961,936	966,091
LONG TERM ASSETS		
11. Long-Term Notes Receivable	-	-
12. Long-Term Investments	-	-
13. Land	-	400,000
14. Buildings, at Historical Cost	-	3,008,284
15. Leasehold Improvements, Historical Cost	19,092	37,461
16. Equipment, at Historical Cost	111,673	720,726
17. Accumulated Depreciation (book methods)	(71,683)	(1,118,974)
18. Deferred Charges	-	-
19. Organization & Pre-Operating Costs	-	21,596
20. Accum Amort - Org/Pre-Op Costs	-	(6,703)
21. Restricted Funds	-	774,525
22. Other Long-Term Assets (specify):	-	-
23. other (specify):	-	-
24. Total Long-Term Assets	59,082	3,836,915
25. Total Assets	#####	4,803,006
CURRENT LIABILITIES		
26. Accounts Payable	581,938	604,317
27. Officer's Accounts Payable	-	-
28. Accounts Payable-Patients Deposits	-	-
29. Short-Term Notes Payable	-	-
30. Accrued Salaries Payable	45,066	45,066
31. Accrued Taxes Payable	32,424	32,424
32. Accrued Real Estate Taxes	-	125,700
33. Accrued Interest Payable	-	9,781
34. Deferred Compensation	2,032	2,032
35. Federal and State Income Taxes	-	-
36. Other Current Liabilities (specify):	259,188	259,188
37. Other Current Liabilities (specify):	#####	1,455,036
38. Total Current Liabilities	#####	2,533,544
LONG TERM LIABILITES		
39.Long-Term Notes Payable	18,140	18,140
40.Mortgage Payable	-	3,129,851
41.Bonds Payable	-	-
42.Deferred Compensation	-	-
43.Other Long-Term Liabilities (specify):	100,825	100,825
44.Other Long-Term Liabilities (specify):	-	-
45.Total Long-Term Liabilities	118,965	3,248,816
46.Total Liabilities	#####	5,782,360
47.Total Equity	#####	(979,354)
48.Total Liabilities and Equity	#####	4,803,006

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	#####
2. Discounts and Allowances for all Levels	#####
Subtotal - Inpatient Care	#####
4. Day Care	-
5. Other Care for Outpatients	-
6. Therapy	408,365.00
7. Oxygen	527.00
Subtotal - Anciliary Revenue	408,892.00
9. Payments for Education	-
10. Other Governmental Grants	-
11. Nurses Aide Training Reimbursements	-
12. Gift and Coffee Shop	-
13. Barber and Beauty Care	872.00
14. Non-Patient Meals	5,139.00
15. Telephone, Television, and Radio	720.00
16. Rental of Facility Space	-
17. Sale of Drugs	72,474.00
18. Sale of Supplies to Non-Patients	-
19. Laboratory	-
20. Radiology and X-Ray	10,169.00
21. Other Medical Services	16,768.00
22. Laundry	-
Subtotal - Other Operating Revenue	106,142.00
24. Contributions	-
25. Interest and Other Investments Income	5.00
Subtotal - Non-Operating Revenue	5.00
27. Other Revenue (specify):	22,096.00
28. Other Revenue (specify):	497.00
Subtotal - Other Revenue	22,593.00
30. Total Revenue	#####
31. General Services	587,065.00
32. Health Care	#####
33. General Administration	529,455.00
34. Ownership	636,268.00
35. Special Cost Centers	168,259.00
35. Provider Participation Fee	169,407.00
37. Other	-
40. Total Expenses	#####
41. Income Before Income Taxes	27,503.00
42. Income Taxes	-
43. Net Income or Loss for the Year	27,503.00