

		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: 0053330

Facility Name: Sauk Valley Senior Living

Address: 1000 Dixon Avenue Rock Falls 61071
Number City Zip Code

County: Whiteside

Telephone Number: (815)625-8510 Fax # (815)625-8443

HFS ID Number:

Date of Initial License for Current Owners: 11/1/2014

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

Paid
Preparer

(Signed) _____ (Date) _____
(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 Sauk Valley Senior Living

0053330 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>55</u>	Skilled (SNF)	<u>55</u>	<u>20,075</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>55</u>	TOTALS	<u>55</u>	<u>20,075</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>7,293</u>	<u>2,126</u>	<u>772</u>	<u>10,191</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>7,293</u>	<u>2,126</u>	<u>772</u>	<u>10,191</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 50.76%

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 11/1/2014

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 11/1/2014 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter number of beds certified 55 and days of care provided 640

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL ☒ 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 Sauk Valley Senior Living # 0053330 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	121,622	6,013	78	127,713		127,713	2,093	129,806			1
2	Food Purchase		67,356		67,356		67,356	(1,536)	65,820			2
3	Housekeeping	50,229	9,823		60,052		60,052	37	60,089			3
4	Laundry	18,060	3,247		21,307		21,307		21,307			4
5	Heat and Other Utilities			74,438	74,438		74,438	122	74,560			5
6	Maintenance	33,324	4,441	13,604	51,369		51,369	1,143	52,512			6
7	Other (specify):* Home Office Ben. Allocation											7
8	TOTAL General Services	223,235	90,880	88,120	402,235		402,235	1,859	404,094			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	652,919	35,135	3,100	691,154		691,154	(2,437)	688,717			10
10a	Therapy			97,587	97,587		97,587		97,587			10a
11	Activities	21,619	220	27	21,866		21,866	(293)	21,573			11
12	Social Services	33,356			33,356		33,356		33,356			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Office Ben. Allocation											15
16	TOTAL Health Care and Programs	707,894	35,355	118,714	861,963		861,963	(2,730)	859,233			16
	C. General Administration											
17	Administrative			159,800	159,800		159,800	(96,952)	62,848			17
18	Directors Fees											18
19	Professional Services			6,891	6,891		6,891	9,336	16,227			19
20	Dues, Fees, Subscriptions & Promotions			5,592	5,592		5,592	(919)	4,673			20
21	Clerical & General Office Expenses		1,663	6,280	7,943		7,943	24,346	32,289			21
22	Employee Benefits & Payroll Taxes			118,694	118,694		118,694	13,646	132,340			22
23	Inservice Training & Education							47	47			23
24	Travel and Seminar							23	23			24
25	Other Admin. Staff Transportation			2,551	2,551		2,551	1,920	4,471			25
26	Insurance-Prop.Liab.Malpractice			16,742	16,742		16,742	270	17,012			26
27	Other (specify):* Home Office Ben. Allocation											27
28	TOTAL General Administration		1,663	316,550	318,213		318,213	(48,283)	269,930			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	931,129	127,898	523,384	1,582,411		1,582,411	(49,154)	1,533,257			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			2,067	2,067		2,067	6,216	8,283			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							130	130			32
33	Real Estate Taxes			22,158	22,158		22,158	124	22,282			33
34	Rent-Facility & Grounds			121,440	121,440		121,440		121,440			34
35	Rent-Equipment & Vehicles			11,786	11,786		11,786	439	12,225			35
36	Other (specify):*											36
37	TOTAL Ownership			157,451	157,451		157,451	6,909	164,360			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		17,890		17,890		17,890		17,890			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			87,317	87,317		87,317		87,317			42
43	Other (specify):*		901	59,801	60,702		60,702	(60,702)				43
44	TOTAL Special Cost Centers		18,791	147,118	165,909		165,909	(60,702)	105,207			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	931,129	146,689	827,953	1,905,771		1,905,771	(102,947)	1,802,824			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,574)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,071)	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	(711)	30		9
10	Interest and Other Investment Income	(29)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(150)	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	(11,121)	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	(40,800)	43		24
25	Fund Raising, Advertising and Promotional	(900)	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	(6,652)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (67,008)		\$	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)	(35,939)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (35,939)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (102,947)		37

*These costs are only allowable if they are necessary to meet minimum
licensing standards. Attach a schedule detailing the items included
on these lines.

C. Are the following expenses included in Sections A to D of pages 3
and 4? If so, they should be reclassified into Section E. Please
reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (1,196)	43	1
2	X-Rays-Part A	(838)	43	2
3	Disallowed Marketing Supplies	(901)	43	3
4	Disallowed Special Events	275	43	4
5	Offset Transportation Revenue	(293)	11	5
6	Disallowed Chamber of Commerce Dues	(1,142)	20	6
7	Disallowed Nursing Supplies	(2,499)	10	7
8	Disallowed Office Supplies	(58)	21	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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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	(6,652)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sauk Valley Senior Living# 0053330

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	2,093	0	0	0	0	0	0	0	0	0	2,093	1
2	Food Purchase	(1,574)	38	0	0	0	0	0	0	0	0	0	(1,536)	2
3	Housekeeping	0	37	0	0	0	0	0	0	0	0	0	37	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	122	0	0	0	0	0	0	0	0	0	122	5
6	Maintenance	0	1,143	0	0	0	0	0	0	0	0	0	1,143	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,574)	3,433	0	0	0	0	0	0	0	0	0	1,859	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	(2,499)	62	0	0	0	0	0	0	0	0	0	(2,437)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(293)	0	0	0	0	0	0	0	0	0	0	(293)	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	(2,792)	62	0	0	0	0	0	0	0	0	0	(2,730)	16
	C. General Administration													
17	Administrative	0	(96,952)	0	0	0	0	0	0	0	0	0	(96,952)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	5,331	0	4,005	0	0	0	0	0	0	0	9,336	19
20	Fees, Subscriptions & Promotions	(1,142)	0	223	0	0	0	0	0	0	0	0	(919)	20
21	Clerical & General Office Expenses	(58)	0	24,404	0	0	0	0	0	0	0	0	24,346	21
22	Employee Benefits & Payroll Taxes	0	0	13,646	0	0	0	0	0	0	0	0	13,646	22
23	Inservice Training & Education	0	0	47	0	0	0	0	0	0	0	0	47	23
24	Travel and Seminar	0	0	23	0	0	0	0	0	0	0	0	23	24
25	Other Admin. Staff Transportation	0	0	1,920	0	0	0	0	0	0	0	0	1,920	25
26	Insurance-Prop.Liab.Malpractice	0	0	270	0	0	0	0	0	0	0	0	270	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(1,200)	(91,621)	40,533	4,005	0	0	0	0	0	0	0	(48,283)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(5,566)	(88,126)	40,533	4,005	0	0	0	0	0	0	0	(49,154)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sauk Valley Senior Living # 0053330 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	(711)	0	5,400	1,527	0	0	0	0	0	0	0	6,216	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(29)	0	159	0	0	0	0	0	0	0	0	130	32
33	Real Estate Taxes	0	0	124	0	0	0	0	0	0	0	0	124	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	439	0	0	0	0	0	0	0	0	439	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(740)	0	6,122	1,527	0	0	0	0	0	0	0	6,909	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(60,702)	0	0	0	0	0	0	0	0	0	0	(60,702)	43
44	TOTAL Special Cost Centers	(60,702)	0	0	0	0	0	0	0	0	0	0	(60,702)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(67,008)	(88,126)	46,655	5,532	0	0	0	0	0	0	0	(102,947)	45

VII. RELATED PARTIES

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

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

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	<u>Dietary</u>	\$	<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>\$ 2,093</u>	<u>\$ 2,093</u>	1
2	V	2	<u>Food</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>38</u>	<u>38</u>	2
3	V	3	<u>Housekeeping</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>37</u>	<u>37</u>	3
4	V	5	<u>Utilities</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>122</u>	<u>122</u>	4
5	V	6	<u>Maintenance</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>1,143</u>	<u>1,143</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>62</u>	<u>62</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>159,800</u>	<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>62,848</u>	<u>(96,952)</u>	11
12	V	19	<u>Professional Services</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>5,331</u>	<u>5,331</u>	12
13	V								13
14	Total			<u>\$ 159,800</u>			<u>\$ 71,674</u>	<u>\$ * (88,126)</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	<u>Dues, Fees, Subs & Promotions</u>	\$	<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	\$ <u>223</u>	\$ <u>223</u>	15
16	V	21	<u>Clerical and General Office</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>24,404</u>	<u>24,404</u>	16
17	V	22	<u>Employee Benefits and Payroll Taxes</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>13,646</u>	<u>13,646</u>	17
18	V	23	<u>Inservice Training & Education</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>47</u>	<u>47</u>	18
19	V	24	<u>Travel and Seminar</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>23</u>	<u>23</u>	19
20	V	25	<u>Other Admin. Staff Transport.</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>1,920</u>	<u>1,920</u>	20
21	V	26	<u>Insurance-Prop./Liab./Malprac.</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>270</u>	<u>270</u>	21
22	V	27	<u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>0</u>		22
23	V	30	<u>Depreciation</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>5,400</u>	<u>5,400</u>	23
24	V	32	<u>Interest</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>159</u>	<u>159</u>	24
25	V	33	<u>Real Estate Taxes</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>124</u>	<u>124</u>	25
26	V	35	<u>Rent-Equipment & Vehicles</u>		<u>Petersen Health Care Management, Inc.</u>	<u>100.00%</u>	<u>439</u>	<u>439</u>	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			\$			\$ <u>46,655</u>	\$ * <u>46,655</u>	39

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

Facility Name & ID Number Sauk Valley Senior Living# 0053330Report Period Beginning: 1/1/2016Ending: 12/31/2016

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 Dietary	\$	Midwest Health Operations, LLC	100.00%	\$ 0	\$ 15
16	V	2 Food		Midwest Health Operations, LLC	100.00%	0	16
17	V	3 Housekeeping		Midwest Health Operations, LLC	100.00%	0	17
18	V	4 Laundry		Midwest Health Operations, LLC	100.00%	0	18
19	V	5 Utilities		Midwest Health Operations, LLC	100.00%	0	19
20	V	6 Maintenance		Midwest Health Operations, LLC	100.00%	0	20
21	V	7 Mgmt. Allocation of Benefits		Midwest Health Operations, LLC	100.00%	0	21
22	V	10 Nursing and Medical Records		Midwest Health Operations, LLC	100.00%	0	22
23	V	15 Mgmt. Allocation of Benefits		Midwest Health Operations, LLC	100.00%	0	23
24	V	17 Administrative		Midwest Health Operations, LLC	100.00%	0	24
25	V	19 Professional Services		Midwest Health Operations, LLC	100.00%	4,005	4,005 25
26	V	20 Dues, Fees, Subs & Promotions		Midwest Health Operations, LLC	100.00%	0	26
27	V	21 Clerical and General Office		Midwest Health Operations, LLC	100.00%	0	27
28	V	22 Employee Benefits & Payroll		Midwest Health Operations, LLC	100.00%	0	28
29	V	23 Inservice Training & Education		Midwest Health Operations, LLC	100.00%	0	29
30	V	24 Travel and Seminar		Midwest Health Operations, LLC	100.00%	0	30
31	V	25 Other Admin. Staff Transport.		Midwest Health Operations, LLC	100.00%	0	31
32	V	26 Insurance-Prop./Liab./Malprac.		Midwest Health Operations, LLC	100.00%	0	32
33	V	30 Depreciation		Midwest Health Operations, LLC	100.00%	1,527	1,527 33
34	V	31 Amortization		Midwest Health Operations, LLC	100.00%	0	34
35	V	32 Interest		Midwest Health Operations, LLC	100.00%	0	35
36	V	33 Real Estate Taxes		Midwest Health Operations, LLC	100.00%	0	36
37	V	34 Rent-Facility and Grounds		Midwest Health Operations, LLC	100.00%	0	37
38	V	35 Rent-Equipment & Vehicles		Midwest Health Operations, LLC	100.00%	0	38
39	Total		\$			\$ 5,532	\$ * 5,532 39

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

Facility Name & ID Number

Sauk Valley Senior Living

0053330

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

Sauk Valley Senior Living

0053330

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

Sauk Valley Senior Living

0053330

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 Sauk Valley Senior Living # 0053330 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 Sauk Valley Senior Living# 0053330

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		Allocation	
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	(col.8/col.4)x col.6	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units		
1	1	Dietary	Resident Days	1,529,234	75	\$ 301,135	\$ 332,773	10,015	\$ 2,093	1
2	2	Food	Resident Days	1,529,234	75	480	0	10,015	38	2
3	3	Housekeeping	Resident Days	1,529,234	75	2,362	2,687	10,015	37	3
4	5	Utilities	Resident Days	1,529,234	75	17,327	0	10,015	122	4
5	6	Maintenance	Resident Days	1,529,234	75	119,427	100,000	10,015	1,143	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,529,234	75	0	0	10,015	0	6
7	9	Medical Director	Resident Days	1,529,234	75	0	0	10,015	0	7
8	10	Nursing and Medical Records	Resident Days	1,529,234	75	9,192	2,054,132	10,015	62	8
9	10A	Therapy	Resident Days	1,529,234	75	0	0	10,015	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,529,234	75	0	0	10,015	0	10
11	17	Administrative	Resident Days	1,529,234	75	4,799,018	5,404,166	10,015	62,848	11
12	19	Professional Services	Resident Days	1,529,234	75	532,666	0	10,015	5,331	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,529,234	75	9,548	0	10,015	223	13
14	21	Clerical and General Office	Resident Days	1,529,234	75	3,376,139	3,458,155	10,015	24,404	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,529,234	75	2,257,824	0	10,015	13,646	15
16	23	Inservice Training & Education	Resident Days	1,529,234	75	23,223	0	10,015	47	16
17	24	Travel and Seminar	Resident Days	1,529,234	75	5,279	0	10,015	23	17
18	25	Other Admin. Staff Transport.	Resident Days	1,529,234	75	236,965	0	10,015	1,920	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,529,234	75	36,398	0	10,015	270	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,529,234	75	0	0	10,015	0	20
21	30	Depreciation	Resident Days	1,529,234	75	540,826	0	10,015	5,400	21
22	32	Interest	Resident Days	1,529,234	75	17,439	0	10,015	159	22
23	33	Real Estate Taxes	Resident Days	1,529,234	75	39,471	0	10,015	124	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,529,234	75	45,727	0	10,015	439	24
25	TOTALS					\$ 12,370,446	\$ 11,351,913		\$ 118,329	25

Facility Name & ID Number Sauk Valley Senior Living# 0053330

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

Midwest Health Operations, LLC

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309)691-8113

Fax Number

(309)691-8622

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	135,078	10	\$	\$	10,015	\$	1
2	2	Food	Resident Days	135,078	10			10,015		2
3	3	Housekeeping	Resident Days	135,078	10			10,015		3
4	4	Laundry	Resident Days	135,078	10			10,015		4
5	5	Utilities	Resident Days	135,078	10			10,015		5
6	6	Maintenance	Resident Days	135,078	10			10,015		6
7	7	Mgmt. Allocation of Benefits	Resident Days	135,078	10			10,015		7
8	10	Nursing and Medical Records	Resident Days	135,078	10			10,015		8
9	15	Mgmt. Allocation of Benefits	Resident Days	135,078	10			10,015		9
10	17	Administrative	Resident Days	135,078	10			10,015		10
11	19	Professional Services	Resident Days	135,078	10	64,090		10,015	4,005	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	135,078	10			10,015		12
13	21	Clerical and General Office	Resident Days	135,078	10			10,015		13
14	22	Employee Benefits & Payroll	Resident Days	135,078	10			10,015		14
15	23	Inservice Training & Education	Resident Days	135,078	10			10,015		15
16	24	Travel and Seminar	Resident Days	135,078	10			10,015		16
17	25	Other Admin. Staff Transport.	Resident Days	135,078	10			10,015		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	135,078	10			10,015		18
19	30	Depreciation	Resident Days	135,078	10	15,191		10,015	1,527	19
20	31	Amortization	Resident Days	135,078	10			10,015		20
21	32	Interest	Resident Days	135,078	10			10,015		21
22	33	Real Estate Taxes	Resident Days	135,078	10			10,015		22
23	34	Rent-Facility and Grounds	Resident Days	135,078	10			10,015		23
24	35	Rent-Equipment & Vehicles	Resident Days	135,078	10			10,015		24
25	TOTALS					\$ 79,281	\$		\$ 5,532	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense			
		YES	NO				Original	Balance						
	A. Directly Facility Related Long-Term													
1							\$					\$	1	
2													2	
3													3	
4													4	
5													5	
	Working Capital													
6													6	
7													7	
8													8	
9	TOTAL Facility Related						\$					\$	9	
	B. Non-Facility Related*													
10								Home Office Allocation-PHCM			159	10		
11								Interest Income Offset			(29)	11		
12													12	
13													13	
14	TOTAL Non-Facility Related						\$					\$	130	14
15	TOTALS (line 9+line14)						\$					\$	130	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.			\$	61,681	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.)			\$	12,644	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(49,037)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	67,436	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.				3,759	
				124	
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.			\$	22,282	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2011		8		
	2012		9		
	2013		10		
	2014	12,422	11		
	2015	12,644	12		
Accrual based on prior year tax bill.					

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 Sauk Valley Senior Living COUNTY Whiteside
FACILITY IDPH LICENSE NUMBER 0053330
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:

12,780

B. General Construction Type:

Exterior

Brick

Frame

Concrete

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:

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

3. Current Period Amortization:

4. Dates Incurred:

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	Land	67,000			1
2					2
3	TOTALS	67,000		\$	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						\$			\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Roof Repair		2016		2,750		7	196	196	196
10	Water Heater		2016		4,109		7	294	294	294
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	Building Improvement Booked					506			(506)	
33										33
34	2016-Home Office Allocation-Building Improvements				4,499			108	108	
35	2016-Home Office Allocation-Land Improvements				414			27	27	
36										36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number Sauk Valley Senior Living

0053330

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 11,772	\$ 506		\$ 625	\$ 119	\$ 490	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	\$ 8,658	\$ 539	\$ 866	\$ 327	5-10 yrs.	\$ 1,299	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Home Office Allocation			6,792	6,792			74
75	TOTALS	\$ 8,658	\$ 539	\$ 7,658	\$ 7,119		\$ 1,299	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 20,430	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 1,045	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 8,283	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 7,238	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,789	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.

Facility Name & ID Number	Sauk Valley Senior Living
--------------------------------------	----------------------------------

0053330

Report Period Beginning: 1/1/2016

Ending: 12/31/2016

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: **H & I Properties**

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:	1998	55	9/1/2015	\$ 121,440	5		3
4	Additions							4
5								5
6								6
7	TOTAL		55		\$ 121,440			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: \$ 12,225 Description: See Attached Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1	2	3	4	
	Use	Model Year and Make	Monthly Lease Payment	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 9/1/2015

Ending **8/31/2020**

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

Fiscal Year Ending	Annual Rent
--------------------	-------------

12. /2017 \$ 121,440

13. 2018 \$ 121,440

14. /2019 \$ 121,440

*** 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.**

Sauk Valley Senior Living
0053330
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	\$	7,651
Dishwasher		701
Laundry Equipment		3,424
Generator		10
Home Office Allocation		439
		<u>12,225</u>
		<u><u>12,225</u></u>

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

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

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

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)										
	Service	Schedule V Line & Column Reference	2	3	4		5	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	\$	2,678	\$ 40,167	\$	2,678	\$ 40,167	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		536	8,039		536	8,039	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		3,292	49,381		3,292	49,381	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				17,890		17,890	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			\$	6,506	\$ 97,587	\$ 17,890	6,506	\$ 115,477	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	\$ 360,443	\$ 360,443	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 19,325)	352,924	352,924	3
4	Supply Inventory (priced at Cost)			4
5	Short-Term Investments			5
6	Prepaid Insurance	16,074	16,074	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Security Deposit	5,082	5,082	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 734,523	\$ 734,523	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost		4,499	14
15	Leasehold Improvements, at Historical Cost	6,859	7,273	15
16	Equipment, at Historical Cost	8,658	8,658	16
17	Accumulated Depreciation (book methods)	(2,281)	(1,789)	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)	\$ 13,236	\$ 18,641	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 747,759	\$ 753,164	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 277,147	\$ 277,147	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	34,886	34,886	30
31	Accrued Taxes Payable (excluding real estate taxes)	51,130	51,130	31
32	Accrued Real Estate Taxes(Sch.IX-B)	67,436	67,436	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	240,082	240,082	36
37	Accrued Management Fees	291,646	291,646	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 962,327	\$ 962,327	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Intercompany Loans	4,109	4,109	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 4,109	\$ 4,109	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 966,436	\$ 966,436	46
47	TOTAL EQUITY(page 18, line 24)	\$ (218,677)	\$ (213,272)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 747,759	\$ 753,164	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (4,450)	1
2	Restatements (describe):		2
3	Prior Period Adjustments Made After Cost Report Was Filed	(16,369)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (20,819)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(197,858)	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)	\$ (197,858)	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)	\$ (218,677)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Sauk Valley Senior Living

0053330

Report Period Beginning: 1/1/2016

Ending: 12/31/2016

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 1,600,970	1
2	Discounts and Allowances for all Levels	(97,380)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,503,590	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	164,220	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 164,220	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,574	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	27,891	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	2,077	20
21	Other Medical Services	5,682	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 37,224	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	29	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 29	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Transportation Revenue</u>	293	28
28a	<u>Miscellaneous Revenue</u>	2,557	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,850	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,707,913	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	402,235	31
32	Health Care	861,963	32
33	General Administration	318,213	33
	B. Capital Expense		
34	Ownership	157,451	34
	C. Ancillary Expense		
35	Special Cost Centers	78,592	35
36	Provider Participation Fee	87,317	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,905,771	40
41	Income before Income Taxes (line 30 minus line 40)**	(197,858)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (197,858)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,044,414	44
45	Private Pay - Net Inpatient Revenue	298,556	45
46	Medicare - Net Inpatient Revenue	132,504	46
47	Other-(specify) <u>Insurance Net Inpatient Revenue</u>	28,116	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 1,503,590	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	\$ 61,107	\$ 29.38	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,508	2,715	69,445	25.58	3
4	Licensed Practical Nurses	7,676	8,245	195,980	23.77	4
5	CNAs & Orderlies	21,747	23,431	258,250	11.02	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,020	2,231	21,384	9.58	9
10	Activity Assistants	28	28	235	8.39	10
11	Social Service Workers	1,893	2,229	33,356	14.96	11
12	Dietician					12
13	Food Service Supervisor	1,900	2,147	27,365	12.75	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,099	10,043	94,257	9.39	15
16	Dishwashers					16
17	Maintenance Workers	1,993	2,066	33,324	16.13	17
18	Housekeepers	5,071	5,611	50,229	8.95	18
19	Laundry	2,061	2,111	18,060	8.56	19
20	Administrator	2,080	2,080	62,848	30.22	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					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 CPC	1,960	2,247	55,026	24.49	32
33	Other(specify) Restorative Aides	1,081	1,135	13,111	11.55	33
34	TOTAL (lines 1 - 33)	63,197	68,399	\$ 993,977 *	\$ 14.53	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	2	\$ 78	L1, C3	35
36	Medical Director	Monthly	18,000	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,221	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)	2	\$ 20,299		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

STATE OF ILLINOIS

Page 21

Facility Name & ID Number

Sauk Valley Senior Living

0053330

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	
Julie Logan		Administrator	0	\$ 62,848	Workers' Compensation Insurance		\$ 18,612	IDPH License Fee		\$ 1,990	
					Unemployment Compensation Insurance		22,304	Advertising: Employee Recruitment			
					FICA Taxes		70,930	Health Care Worker Background Check			
					Employee Health Insurance		1,986	(Indicate # of checks performed 44)		442	
					Employee Meals			Patient Background Checks		22 442	
					Illinois Municipal Retirement Fund (IMRF)*			Miscellaneous Licenses & Permits		576	
					Employee Relations		467	Miscellaneous Dues & Subscriptions		2,142	
					Employee Retirement		4,395	Home Office Allocation		223	
					Home Office Allocation		13,646				
TOTAL (agree to Schedule V, line 17, col. 1)											
(List each licensed administrator separately.)				\$ 62,848							
B. Administrative - Other											
Description			Amount					Less: Public Relations Expense		(1,142)	
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 159,800					Non-allowable advertising		()	
								Yellow page advertising		()	
				TOTAL (agree to Schedule V, line 22, col.8)			\$ 132,340	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 4,673	
TOTAL (agree to Schedule V, line 17, col. 3)				\$ 159,800	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**			
(Attach a copy of any management service agreement)											
C. Professional Services											
Vendor/Payee		Type	Amount	Description		Line #	Amount	Description		Amount	
Ability Network		Computer Services	\$ 4,703					Out-of-State Travel		\$	
Comcast Cable		Computer Services	1,268								
Carewatch		Computer Services	920	N/A							
								In-State Travel			
								Seminar Expense			
								Home Office Allocation		23	
								Entertainment Expense		()	
								(agree to Sch. V, line 24, col. 8)			
								TOTAL		\$ 23	
TOTAL (agree to Schedule V, line 19, column 3)				\$ 6,891	TOTAL			\$			
(For legal fee disclosure, see page 39 of instructions)											

* Attach copy of IMRF notifications

**See instructions.

Sauk Valley Senior Living
0053330
Period Beginning
Period End

1/1/2016
12/31/2016

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		6,891
Home Office Allocation		
Lucie, Scalf, and Bougher	Legal	24
Miscellaneous	Legal	10
Miller Hall and Triggs	Legal	41
Healthcare Resources International	Legal	205
Hunziker Law	Legal	49
Lexis Nexis	Legal	4
Illinois Secretary of State	Legal	25
Hughes, Socol, Piers	Legal	1,005
SB2	Legal	1,206
CliftonLarson Allen	Accountants	214
Ginoli & Co.	Accountants	2,466
Miscellaneous	Computer Services	27
Change Healthcare	Computer Services	4
PTC Select	Computer Services	2
Advanced Answers on Demand	Computer Services	1,877
Stratus Networks	Computer Services	191
Kemper Technology	Computer Services	126
AT&T	Computer Services	3
Ability Network	Computer Services	800
CIAN	Computer Services	95
Comcast	Computer Services	16
CCH	Computer Services	6
Charter Communications	Computer Services	19
Allscripts	Computer Services	279
ATS	Computer Services	126
Allpayer Exchange	Computer Services	6
Optimizer	Other Prof Fees	19
Ankura	Other Prof Fees	146
David Budde	Other Prof Fees	17
Bruner, Cooper, Zuck	Other Prof Fees	42
Marotta, Gund, Budd, Dzerda	Other Prof Fees	262
Professional Software and Services	Other Prof Fees	10
Hughes Valuation Services	Other Prof Fees	13
Alan Litwiller	Other Prof Fees	1

Total (agree to Schedule V, line 19, column 8)	<u><u>16,227</u></u>
--	----------------------

XX. GENERAL INFORMATION:

(1)

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

No

(2)

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

Yes
IHCA-\$1,000

(3)

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

No
N/A

(4)

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

No
N/A

(5)

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

Yes
7 yrs.

(6)

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

\$ 8,687 Line 10

(7)

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

Yes

(8)

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

No
N/A

(9)

Are you presently operating under a sublease agreement?

YES X NO

(10)

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

(11)

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

\$ 87,317

(12)

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

No

(13)

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

Yes

(14)

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

No

(15)

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

\$ 0
Yes
Indicate the amount. \$ 1,574

(16)

Travel and Transportation

a.

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

No

b.

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

Yes
293

c.

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

100

d.

Have vehicle usage logs been maintained?

Adequate records have been maintained.

e.

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

Yes

f.

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

Yes

g.

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

No
N/A

(17)

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

Yes
Ginoli and Company

(18)

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

Yes

(19)

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

No

HFS 3745 (N-4-99)

IL478-2471

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB- SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB- SCHED.	LINE NO.	COL. NO.
Adjustment Deta	-102,947	equal to	-102,947	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expensi	130	equal to	130	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax	22,282	equal to	22,282	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp	0	equal to	0	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Cost	8,283	equal to	8,283	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	121,440	equal to	121,440	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	12,225	equal to	12,225	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Traini	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to	0	0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Service	97,587	equal to	97,587	0	O.K.	Pg16 Z12+Z14..	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv.- S	17,890	equal to	17,890	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. Ge	402,235	equal to	402,235	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. He	861,963	equal to	861,963	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Ad	318,213	equal to	318,213	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ov	157,451	equal to	157,451	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Sp	78,592	equal to	78,592	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+†	N/A	38to41+43	4
Income Stat. Prt	87,317	equal to	87,317	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	652,919	equal to	652,919	0	O.K.	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aid	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed T	0	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	21,619	equal to	21,619	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Ser	33,356	equal to	33,356	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	121,622	equal to	121,622	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenar	33,324	equal to	33,324	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekee	50,229	equal to	50,229	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	18,060	equal to	18,060	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administre	62,848	equal to	62,848	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	0	equal to	#VALUE!	#VALUE!		Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical D	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries A	993,977	equal to	931,129	62,848	FAILED	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consults	78	< or = to	78	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	18,000	< or = to	18,000	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & c	2,221	< or = to	3,100	-879	O.K.	Pg20 X14..X16+	B. & C.	7to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consults	0	< or = to	27	-27	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service C	0	< or = to		0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- A	62,848	equal to	62,848	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- A	159,800	equal to	159,800	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- F	6,891	equal to	6,891	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- B	132,340	equal to	132,340	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- S	4,673	equal to	4,673	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- S	23	equal to	23	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Parti	87,317	equal to	87,317	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Emp	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide train	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicar	640	equal to	772	-132	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for n	-35,939	equal to	#VALUE!	#VALUE!	#VALUE!	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4I	B.	14	8
Total loan balan	0	equal to	0	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27.	N/A	29+39-41	2
Real estate tax i	67,436	equal to	67,436	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	0	equal to		#VALUE!	#VALUE!	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	11,772	equal to	11,772	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and '	8,658	equal to	8,658	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated de	1,789	equal to	1,789	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equ	-218,677	equal to	-218,677	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (los	-197,858	equal to	-197,858	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Balance Sheet	747,759	equal to	747,759	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	121,622	6,013	78	127,713	0	127,713	2,093	129,806
2. Food Purchase	0	67,356	0	67,356	0	67,356	-1,536	65,820
3. Housekeeping	50,229	9,823	0	60,052	0	60,052	37	60,089
4. Laundry	18,060	3,247	0	21,307	0	21,307	0	21,307
5. Heat and Other Utilities	0	0	74,438	74,438	0	74,438	122	74,560
6. Maintenance	33,324	4,441	13,604	51,369	0	51,369	1,143	52,512
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	223,235	90,880	88,120	402,235	0	402,235	1,859	404,094
9. Medical Director	0	0	18,000	18,000	0	18,000	0	18,000
10. Nursing & Medical Records	652,919	35,135	3,100	691,154	0	691,154	-2,437	688,717
10a. Therapy	0	0	97,587	97,587	0	97,587	0	97,587
11. Activities	21,619	220	27	21,866	0	21,866	-293	21,573
12. Social Services	33,356	0	0	33,356	0	33,356	0	33,356
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	707,894	35,355	118,714	861,963	0	861,963	-2,730	859,233
17. Administrative	0	0	159,800	159,800	0	159,800	-96,952	62,848
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	6,891	6,891	0	6,891	9,336	16,227
20. Fees, Subscriptions & Promotion	0	0	5,592	5,592	0	5,592	-919	4,673
21. Clerical & General Office	0	1,663	6,280	7,943	0	7,943	24,346	32,289
22. Employee Benefits & Payroll	0	0	118,694	118,694	0	118,694	13,646	132,340
23. Inservice Training & Education	0	0	0	0	0	0	47	47
24. Travel and Seminar	0	0	0	0	0	0	23	23
25. Other Admin. Staff Trans	0	0	2,551	2,551	0	2,551	1,920	4,471
26. Insurance-Prop.Liab.Malpractice	0	0	16,742	16,742	0	16,742	270	17,012
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	0	1,663	316,550	318,213	0	318,213	-48,283	269,930
29. Total General Administrative	931,129	127,898	523,384	1,582,411	0	1,582,411	-49,154	#####
30. Depreciation	0	0	2,067	2,067	0	2,067	6,216	8,283
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	0	0	0	0	130	130
33. Real Estate	0	0	22,158	22,158	0	22,158	124	22,282
34. Rent - Facility & Grounds	0	0	121,440	121,440	0	121,440	0	121,440
35. Rent - Equipment & Vehicles	0	0	11,786	11,786	0	11,786	439	12,225
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	157,451	157,451	0	157,451	6,909	164,360
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	17,890	0	17,890	0	17,890	0	17,890
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	87,317	87,317	0	87,317	0	87,317
43. Other (specify):*	0	901	59,801	60,702	0	60,702	-60,702	0
44. Total Special Cost Ce	0	18,791	147,118	165,909	0	165,909	-60,702	105,207
45. Grand Total	931,129	146,689	827,953	1,905,771	0	1,905,771	-102,947	#####

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	360,443	360,443
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	352,924	352,924
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	16,074	16,074
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	5,082	5,082
10. Total current assets	734,523	734,523
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	0	0
14. Buildings, at Historical Cost	0	4,499
15. Leasehold Improvements, Historical Cost	6,859	7,273
16. Equipment, at Historical Cost	8,658	8,658
17. Accumulated Depreciation (book methods)	-2,281	-1,789
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	13,236	18,641
25. Total Assets	747,759	753,164
CURRENT LIABILITIES		
26. Accounts Payable	277,147	277,147
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	34,886	34,886
31. Accrued Taxes Payable	51,130	51,130
32. Accrued Real Estate Taxes	67,436	67,436
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	240,082	240,082
37. Other Current Liabilities (specify):	291,646	291,646
38. Total Current Liabilities	962,327	962,327
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	0
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	4,109	4,109
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	4,109	4,109
46.Total Liabilities	966,436	966,436
47.Total Equity	-218,677	-213,272
48.Total Liabilities and Equity	747,759	753,164

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	1,600,970
2. Discounts and Allowances for all Levels	-97,380
Subtotal - Inpatient Care	1,503,590
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	164,220
7. Oxygen	0
Subtotal - Anciliary Revenue	164,220
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	1,574
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	27,891
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiology and X-Ray	2,077
21. Other Medical Services	5,682
22. Laundry	0
Subtotal - Other Operating Revenue	37,224
24. Contributions	0
25. Interest and Other Investments Income	29
Subtotal - Non-Operating Revenue	29
27. Other Revenue (specify):	293
28. Other Revenue (specify):	2,557
Subtotal - Other Revenue	2,850
30. Total Revenue	1,707,913
31. General Services	368,799
32. Health Care	919,318
33. General Administration	303,335
34. Ownership	113,238
35. Special Cost Centers	62,178
35. Provider Participation Fee	83,383
37. Other	0
40. Total Expenses	1,850,251
41. Income Before Income Taxes	-142,338
42. Income Taxes	0
43. Net Income or Loss for the Year	-142,338