

		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: 0053066

Facility Name: Shelbyville Reh & Hlth C Ctr

Address: 2116 S 3rd Dacey Dr Shelbyville 62565
Number City Zip Code

County: Shelby

Telephone Number: (217) 774-2138 Fax # (217) 774-2317

HFS ID Number:

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

Type of Ownership:

VOLUNTARY,NON-PROFIT
Charitable Corp.
Trust
IRS Exemption Code

X PROPRIETARY
Individual
Partnership
Corporation
"Sub-S" Corp.
X 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 Shelbyville Reh & Hlth C Ctr

0053066 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>12</u>	Skilled (SNF)	<u>12</u>	<u>4,380</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>68</u>	Intermediate (ICF)	<u>68</u>	<u>24,820</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>80</u>	TOTALS	<u>80</u>	<u>29,200</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>609</u>	<u>609</u>	8
9	SNF/PED					9
10	ICF	<u>7,986</u>	<u>4,062</u>		<u>12,048</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>7,986</u>	<u>4,062</u>	<u>609</u>	<u>12,657</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 43.35%

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 10/1/2005

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

YES ☒ Date 10/1/2005 NO ☐

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

YES ☒ NO ☐ If YES, enter number of beds certified 12 and days of care provided 538

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 Shelbyville Reh & Hlth C Ctr # 0053066 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	115,097	10,933	323	126,353		126,353	2,658	129,011			1
2	Food Purchase		87,352		87,352		87,352	(1,811)	85,541			2
3	Housekeeping	62,754	11,470		74,224		74,224	46	74,270			3
4	Laundry	8,148	5,802		13,950		13,950		13,950			4
5	Heat and Other Utilities			61,822	61,822		61,822	155	61,977			5
6	Maintenance	29,810	8,784	18,464	57,058		57,058	1,451	58,509			6
7	Other (specify):* <u>Home Office Ben. Allocation</u>											7
8	TOTAL General Services	215,809	124,341	80,609	420,759		420,759	2,499	423,258			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	556,515	58,906	4,441	619,862		619,862	(3,300)	616,562			10
10a	Therapy			76,866	76,866		76,866		76,866			10a
11	Activities	27,508	616	567	28,691		28,691	(2,272)	26,419			11
12	Social Services		42		42		42		42			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	584,023	59,564	93,874	737,461		737,461	(5,572)	731,889			16
	C. General Administration											
17	Administrative			187,600	187,600		187,600	(118,183)	69,417			17
18	Directors Fees											18
19	Professional Services			5,489	5,489		5,489	17,205	22,694			19
20	Dues, Fees, Subscriptions & Promotions			7,260	7,260		7,260	(37)	7,223			20
21	Clerical & General Office Expenses	35,824	1,684	11,102	48,610		48,610	30,904	79,514			21
22	Employee Benefits & Payroll Taxes			124,225	124,225		124,225	17,329	141,554			22
23	Inservice Training & Education							59	59			23
24	Travel and Seminar							29	29			24
25	Other Admin. Staff Transportation			6,537	6,537		6,537	2,438	8,975			25
26	Insurance-Prop.Liab.Malpractice			24,490	24,490		24,490	343	24,833			26
27	Other (specify):* <u>Home Office Ben. Allocation</u>											27
28	TOTAL General Administration	35,824	1,684	366,703	404,211		404,211	(49,913)	354,298			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	835,656	185,589	541,186	1,562,431		1,562,431	(52,986)	1,509,445			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			49,671	49,671		49,671	8,997	58,668			30
31	Amortization of Pre-Op. & Org.							18,277	18,277			31
32	Interest							27,544	27,544			32
33	Real Estate Taxes			32,346	32,346		32,346	158	32,504			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			24,928	24,928		24,928	558	25,486			35
36	Other (specify):*											36
37	TOTAL Ownership			106,945	106,945		106,945	55,534	162,479			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		15,409		15,409		15,409		15,409			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			117,293	117,293		117,293		117,293			42
43	Other (specify):*	30,893	594	22,940	54,427		54,427	(54,427)				43
44	TOTAL Special Cost Centers	30,893	16,003	140,233	187,129		187,129	(54,427)	132,702			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	866,549	201,592	788,364	1,856,505		1,856,505	(51,879)	1,804,626			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	(1,859)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,228)	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	2,139	30		9
10	Interest and Other Investment Income	(44)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(126)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(6,017)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(5,000)	43		24
25	Fund Raising, Advertising and Promotional	(3,970)	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	(42,144)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (60,249)		\$	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)	8,370	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 8,370		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (51,879)		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (2,445)	43	1
2	X-Rays-Part A	(1,501)	43	2
3	Disallowed Marketing Salaries	(30,893)	43	3
4	Offset Transportation Revenue	(2,272)	11	4
5	Offset Miscellaneous Office Supplies Revenue	(87)	21	5
6	Disallowed Special Events	(1,193)	43	6
7	Resident Flowers	(54)	20	7
8	Offset Miscellaneous Nursing Supplies Revenue	(3,379)	10	8
9	Disallowed Chamber of Commerce Dues	(320)	20	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
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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	(42,144)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Shelbyville Reh & Hlth C Ctr# 0053066

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	2,658	0	0	0	0	0	0	0	0	0	2,658	1
2	Food Purchase	(1,859)	48	0	0	0	0	0	0	0	0	0	(1,811)	2
3	Housekeeping	0	46	0	0	0	0	0	0	0	0	0	46	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	155	0	0	0	0	0	0	0	0	0	155	5
6	Maintenance	0	1,451	0	0	0	0	0	0	0	0	0	1,451	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(1,859)	4,358	0	0	0	0	0	0	0	0	0	2,499	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	(3,379)	79	0	0	0	0	0	0	0	0	0	(3,300)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(2,272)	0	0	0	0	0	0	0	0	0	0	(2,272)	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	(5,651)	79	0	0	0	0	0	0	0	0	0	(5,572)	16
	C. General Administration													
17	Administrative	0	(118,183)	0	0	0	0	0	0	0	0	0	(118,183)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	6,770	0	10,435	0	0	0	0	0	0	0	17,205	19
20	Fees, Subscriptions & Promotions	(374)	0	283	0	0	0	0	0	0	0	0	(91)	20
21	Clerical & General Office Expenses	(87)	0	30,991	0	0	0	0	0	0	0	0	30,904	21
22	Employee Benefits & Payroll Taxes	0	0	17,329	0	0	0	0	0	0	0	0	17,329	22
23	Inservice Training & Education	0	0	59	0	0	0	0	0	0	0	0	59	23
24	Travel and Seminar	0	0	29	0	0	0	0	0	0	0	0	29	24
25	Other Admin. Staff Transportation	0	0	2,438	0	0	0	0	0	0	0	0	2,438	25
26	Insurance-Prop.Liab.Malpractice	0	0	343	0	0	0	0	0	0	0	0	343	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(461)	(111,413)	51,472	10,435	0	0	0	0	0	0	0	(49,967)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(7,971)	(106,976)	51,472	10,435	0	0	0	0	0	0	0	(53,040)	29

Summary B

Facility Name & ID Number	Shelbyville Reh & Hlth C Ctr	#	0053066	Report Period Beginning:	1/1/2016	Ending:	12/31/2016
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SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

VII. RELATED PARTIES

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

[illegible]

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	\$	Petersen Health Care Management, Inc.	100.00%	\$ 2,658	\$ 2,658	1
2	V	2	Food		Petersen Health Care Management, Inc.	100.00%	48	48	2
3	V	3	Housekeeping		Petersen Health Care Management, Inc.	100.00%	46	46	3
4	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	155	155	4
5	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	1,451	1,451	5
6	V	7	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		6
7	V	9	Medical Director		Petersen Health Care Management, Inc.	100.00%	0		7
8	V	10	Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	79	79	8
9	V	10A	Therapy		Petersen Health Care Management, Inc.	100.00%	0		9
10	V	15	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		10
11	V	17	Administrative	187,600	Petersen Health Care Management, Inc.	100.00%	69,417	(118,183)	11
12	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	6,770	6,770	12
13	V								13
14	Total			\$ 187,600			\$ 80,624	\$ * (106,976)	14

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	20	Dues, Fees, Subs & Promotions	\$	Petersen Health Care Management, Inc.	100.00%	\$ 283	\$ 283	15
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	30,991	30,991	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	17,329	17,329	17
18	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	59	59	18
19	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	29	29	19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	2,438	2,438	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	343	343	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%	6,858	6,858	23
24	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	201	201	24
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	158	158	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	558	558	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			\$			\$ 59,247	\$ * 59,247	39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	\$	Petersen Health Wellness, LLC	100.00%	\$ 0	\$	15
16	V	2	Food		Petersen Health Wellness, LLC	100.00%	0		16
17	V	3	Housekeeping		Petersen Health Wellness, LLC	100.00%	0		17
18	V	4	Laundry		Petersen Health Wellness, LLC	100.00%	0		18
19	V	5	Utilities		Petersen Health Wellness, LLC	100.00%	0		19
20	V	6	Maintenance		Petersen Health Wellness, LLC	100.00%	0		20
21	V	7	Mgmt. Allocation of Benefits		Petersen Health Wellness, LLC	100.00%	0		21
22	V	10	Nursing and Medical Records		Petersen Health Wellness, LLC	100.00%	0		22
23	V	15	Mgmt. Allocation of Benefits		Petersen Health Wellness, LLC	100.00%	0		23
24	V	17	Administrative		Petersen Health Wellness, LLC	100.00%	0		24
25	V	19	Professional Services		Petersen Health Wellness, LLC	100.00%	10,435	10,435	25
26	V	20	Dues, Fees, Subs & Promotions		Petersen Health Wellness, LLC	100.00%	0		26
27	V	21	Clerical and General Office		Petersen Health Wellness, LLC	100.00%	0		27
28	V	22	Employee Benefits & Payroll		Petersen Health Wellness, LLC	100.00%	0		28
29	V	23	Inservice Training & Education		Petersen Health Wellness, LLC	100.00%	0		29
30	V	24	Travel and Seminar		Petersen Health Wellness, LLC	100.00%	0		30
31	V	25	Other Admin. Staff Transport.		Petersen Health Wellness, LLC	100.00%	0		31
32	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Wellness, LLC	100.00%	0		32
33	V	30	Depreciation		Petersen Health Wellness, LLC	100.00%	0		33
34	V	31	Amortization		Petersen Health Wellness, LLC	100.00%	18,277	18,277	34
35	V	32	Interest		Petersen Health Wellness, LLC	100.00%	27,387	27,387	35
36	V	33	Real Estate Taxes		Petersen Health Wellness, LLC	100.00%	0		36
37	V	34	Rent-Facility and Grounds		Petersen Health Wellness, LLC	100.00%	0		37
38	V	35	Rent-Equipment & Vehicles		Petersen Health Wellness, LLC	100.00%	0		38
39	Total			\$			\$ 56,099	\$ * 56,099	39

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

Facility Name & ID Number

Shelbyville Reh & Hlth C Ctr

0053066

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

Shelbyville Reh & Hlth C Ctr

0053066

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

Shelbyville Reh & Hlth C Ctr

0053066

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Twin Lakes Rehab & Health Care Center	Paris				1
2			Vandalia Rehab & Health Care Center	Vandalia				2
3			Watseka Health Care Center	Watseka				3
4			Westside Rehab & Care Center	West Frankfort				4
5			Whispering Oaks	Rosiclare				5
6			White Oak Rehab & Health Care Center	Mt. Vernon				6
7			Willow Rose Rehab & Health Care Center	Jerseyville				7
8			Sheldon Health Care Center	Sheldon				8
9			Tuscola Health Care Center	Tuscola				9
10			Effingham Health Care Center	Effingham				10
11			Collinsville Health Care Center	Collinsville				11
12			Ozark Rehab & Health Care Center	Osage Beach, MO				12
13			Tarkio Rehab & Health Care Center	Tarkio, MO				13
14			Shangri-la Rehab & Living Center	Blue Springs, MO				14
15			Prairie Rose Care Center	Pana				15
16			Illini Heritage Rehab & Health Center	Champaign				16
17			Courtyard Estates of Kewanee	Kewanee				17
18			Courtyard Estates of Bradford	Bradford				18
19			Courtyard Estates of Galva	Galva				19
20			Courtyard Estates of Walcott	Walcott				20
21			Courtyard Village of Kewanee	Kewanee				21
22			Lakewood Village	Charleston				22
23			Courtyard Estates of Monmouth	Monmouth				23
24			Riverview Estates	Havana				24
25			Simple Blessings	Casey				25
26			Courtyard Estates of Bushnell	Bushnell				26
27			Courtyard Estates of Canton	Canton				27
28			Legacy Estates of Monmouth	Monmouth				28
29			Courtyard Estates of Sullivan	Sullivan				29
30			Courtyard Estates of Peoria	Peoria				30

Facility Name & ID Number

Shelbyville Reh & Hlth C Ctr

0053066

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Cornerstone Health and Rehabilitation	Peoria				1
2			Rock River Gardens	Sterling				2
3			Sauk Valley Senior Living & Rehabilitation	Rock Falls				3
4			Courtyard Estates of Farmington	Farmington				4
5			Courtyard Estates of Knoxville	Knoxville				5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Shelbyville Reh & Hlth C Ctr # 0053066 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 Shelbyville Reh & Hlth C Ctr# 0053066

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	12,942	\$ 2,658	1
2	2	Food	Resident Days	75	5,673	0	12,942	48	2
3	3	Housekeeping	Resident Days	75	5,456	2,897	12,942	46	3
4	5	Utilities	Resident Days	75	18,209	0	12,942	155	4
5	6	Maintenance	Resident Days	75	170,632	137,057	12,942	1,451	5
6	7	Mgmt. Allocation of Benefits	Resident Days	75	0	0	12,942	0	6
7	9	Medical Director	Resident Days	75	0	0	12,942	0	7
8	10	Nursing and Medical Records	Resident Days	75	9,261	1,782,521	12,942	79	8
9	10A	Therapy	Resident Days	75	0	0	12,942	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	75	0	0	12,942	0	10
11	17	Administrative	Resident Days	75	4,899,467	5,473,961	12,942	69,417	11
12	19	Professional Services	Resident Days	75	795,918	0	12,942	6,770	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	75	33,278	0	12,942	283	13
14	21	Clerical and General Office	Resident Days	75	3,643,535	3,756,135	12,942	30,991	14
15	22	Employee Benefits and Payroll Ta	Resident Days	75	2,037,314	0	12,942	17,329	15
16	23	Inservice Training & Education	Resident Days	75	6,986	0	12,942	59	16
17	24	Travel and Seminar	Resident Days	75	3,389	0	12,942	29	17
18	25	Other Admin. Staff Transport.	Resident Days	75	286,637	0	12,942	2,438	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	75	40,378	0	12,942	343	19
20	27	Mgmt. Allocation of Benefits	Resident Days	75	0	0	12,942	0	20
21	30	Depreciation	Resident Days	75	806,271	0	12,942	6,858	21
22	32	Interest	Resident Days	75	23,686	0	12,942	201	22
23	33	Real Estate Taxes	Resident Days	75	18,560	0	12,942	158	23
24	35	Rent-Equipment & Vehicles	Resident Days	75	65,550	0	12,942	558	24
25	TOTALS				\$ 13,182,740	\$ 11,510,481		\$ 139,871	25

Facility Name & ID Number Shelbyville Reh & Hlth C Ctr# 0053066

Report Period Beginning:

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Petersen Health Wellness, LLC

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309)691-8113

Fax Number

(309)691-8622

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6			
1	1	Dietary	Resident Days	94,948	7	\$	\$	12,942	\$	1
2	2	Food	Resident Days	94,948	7			12,942		2
3	3	Housekeeping	Resident Days	94,948	7			12,942		3
4	4	Laundry	Resident Days	94,948	7			12,942		4
5	5	Utilities	Resident Days	94,948	7			12,942		5
6	6	Maintenance	Resident Days	94,948	7			12,942		6
7	7	Mgmt. Allocation of Benefits	Resident Days	94,948	7			12,942		7
8	10	Nursing and Medical Records	Resident Days	94,948	7			12,942		8
9	15	Mgmt. Allocation of Benefits	Resident Days	94,948	7			12,942		9
10	17	Administrative	Resident Days	94,948	7			12,942		10
11	19	Professional Services	Resident Days	94,948	7	76,557		12,942	10,435	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	94,948	7			12,942		12
13	21	Clerical and General Office	Resident Days	94,948	7			12,942		13
14	22	Employee Benefits & Payroll	Resident Days	94,948	7			12,942		14
15	23	Inservice Training & Education	Resident Days	94,948	7			12,942		15
16	24	Travel and Seminar	Resident Days	94,948	7			12,942		16
17	25	Other Admin. Staff Transport.	Resident Days	94,948	7			12,942		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	94,948	7			12,942		18
19	30	Depreciation	Resident Days	94,948	7			12,942		19
20	31	Amortization	Resident Days	94,948	7	134,086		12,942	18,277	20
21	32	Interest	Resident Days	94,948	7	200,924		12,942	27,387	21
22	33	Real Estate Taxes	Resident Days	94,948	7			12,942		22
23	34	Rent-Facility and Grounds	Resident Days	94,948	7			12,942		23
24	35	Rent-Equipment & Vehicles	Resident Days	94,948	7			12,942		24
25	TOTALS					\$ 411,567	\$		\$ 56,099	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1												\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$	\$			\$		9
	B. Non-Facility Related*												
10								Interest Income Offset				(44)	10
11								Home Office Allocation-PHCM				201	11
12								Home Office Allocation-PHW				27,387	12
13													13
14	TOTAL Non-Facility Related						\$	\$			\$	27,544	14
15	TOTALS (line 9+line14)						\$	\$			\$	27,544	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

[illegible]

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 Shelbyville Reh & Hlth C Ctr COUNTY Shelby
FACILITY IDPH LICENSE NUMBER 0053066
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:

16,099

B. General Construction Type:

Exterior

Brick

Frame

Wood

Number of Stories

1

C. Does the Operating Entity?

☒

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☒

YES

☐

NO

If so, please complete the following:

1. Total Amount Incurred:

188,175

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

20

3. Current Period Amortization:

18,277

4. Dates Incurred:

2013-2014

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.					
	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	80,150	2005	\$ 47,250	1
2					2
3	TOTALS	80,150		\$ 47,250	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	80		2005	1971	\$ 855,750	\$	25	\$ 34,230	\$ 34,230	\$ 393,645
5										
6										
7										
8										
	Improvement Type**									
9	Original Land Improvements			2005	15,000		15	1,000	1,000	11,500
10	Sidewalks			2006	6,365		15	424	424	4,452
11	Water Heater			2006	6,609		10	661	661	6,277
12	Building Repair (Wind Damage)			2007	4,308		15	287	287	2,727
13	Sprinkler Installation			2008	5,990		7			5,990
14	Sprinkler System Repair			2009	7,455		7	532	532	7,455
15	Dry Pipe Valve Repair			2010	3,869		7	552	552	3,588
16	Sprinkler Line Repair			2010	4,106		7	586	586	3,809
17	Sprinkler Replacement			2011	17,599		15	1,174	1,174	5,870
18	Water Heater			2013	5,850		7	836	836	2,926
19	Sidewalks			2013	4,850		15	324	324	1,134
20	Nurse's Station Construction			2013	27,007		25	1,080	1,080	3,780
21	Compressor and Piping Repair			2014	5,741		7	820	820	2,050
22	Roof Repair			2014	2,556		7	365	365	913
23	Water Heater			2014	5,844		7	835	835	2,088
24	Water Heater			2015	3,813		7	546	546	819
25	Water Heater			2015	3,846		7	550	550	825
26	Exterior Landscaping			2016	6,250		7	446	446	446
27										
28										
29										
30	Land Improvements Booked					1,424			(1,424)	
31	Building Booked					34,256			(34,256)	
32	Building Improvement Booked					8,359			(8,359)	
33										
34	2016-Home Office Allocation-Building Improvements				5,714			137	137	
35	2016-Home Office Allocation-Land Improvements				526			34	34	
36										

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
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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)		\$ 999,048	\$ 44,039		\$ 45,419	\$ 1,380	\$ 460,294	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	\$ 62,848	\$ 4,250	\$ 6,285	\$ 2,035	5-10 yrs.	\$ 34,260	71
72	Current Year Purchases	3,886	46	277	231	7 yrs.	277	72
73	Fully Depreciated Assets	181,719					181,719	73
74	Home Office Allocation			6,687	6,687			74
75	TOTALS	\$ 248,453	\$ 4,296	\$ 13,249	\$ 8,953		\$ 216,256	75

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

E. Summary of Care-Related Assets					1	2
		Reference			Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)			\$	1,294,751
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	48,335
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	58,668
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	10,333
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	676,550

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

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

☐ YES
☐ NO

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

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

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

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

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

15. Is Movable equipment rental included in building rental?
- ☒ YES
☐ NO
16. Rental Amount for movable equipment: \$ 18,548
- Description: See Attached Schedule 14A
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Vehicle	2012 Ford E150	\$ 578.17	\$ 6,938	17
18					18
19					19
20					20
21	TOTAL		\$ 578.17	\$ 6,938	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.

Shelbyville Reh & Hlth C Ctr
0053066
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	\$	11,070
Dishwasher		701
Copier		6,219
Home Office Allocation		558
		<u>18,548</u>

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES
☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM☐
IN OTHER FACILITY☐
COMMUNITY COLLEGE☐
HOURS PER CNA_____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM☐
IN OTHER FACILITY☐
HOURS PER CNA_____

B. EXPENSES

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

		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)	\$			

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	\$	1,991	\$ 29,872	\$	1,991	\$ 29,872	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		497	7,448		497	7,448	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		2,636	39,546		2,636	39,546	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				15,409		15,409	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)									
10			hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	5,124	\$ 76,866	\$ 15,409	5,124	\$ 92,275	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	\$ (250,515)	\$ (250,515)	1
2	Cash-Patient Deposits	161	161	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 40,673)	498,099	498,099	3
4	Supply Inventory (priced at Cost)	6,592	6,592	4
5	Short-Term Investments			5
6	Prepaid Insurance	23,137	23,137	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Prepaid Expenses	495	495	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 277,969	\$ 277,969	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	68,615	47,250	13
14	Buildings, at Historical Cost	855,750	861,464	14
15	Leasehold Improvements, at Historical Cost	109,083	137,584	15
16	Equipment, at Historical Cost	248,453	248,453	16
17	Accumulated Depreciation (book methods)	(667,931)	(676,550)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Intercompany Loans	2,793	2,793	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 616,763	\$ 620,994	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 894,732	\$ 898,963	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 291,911	\$ 291,911	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	43,351	43,351	30
31	Accrued Taxes Payable (excluding real estate taxes)	22,512	22,512	31
32	Accrued Real Estate Taxes(Sch.IX-B)	32,808	32,808	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	61,835	61,835	36
37	Accrued Management Fees	141,635	141,635	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 594,052	\$ 594,052	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 594,052	\$ 594,052	46
47	TOTAL EQUITY(page 18, line 24)	\$ 300,680	\$ 304,911	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 894,732	\$ 898,963	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 65,871	1
2	Restatements (describe):		2
3	Prior Period Adjustments Made After Cost Reports Were Filed	(18,001)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 47,870	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	252,810	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)	\$ 252,810	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)	\$ 300,680	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Shelbyville Reh & Hlth C Ctr

0053066

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	\$ 1,989,270	1
2	Discounts and Allowances for all Levels	(56,277)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,932,993	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	135,295	6
7	Oxygen	263	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 135,558	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	1,859	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	27,239	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	2,989	20
21	Other Medical Services	2,895	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 34,982	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	44	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 44	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Transportation Revenue</u>	2,272	28
28a	<u>Miscellaneous Revenue</u>	3,466	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 5,738	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,109,315	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	420,759	31
32	Health Care	737,461	32
33	General Administration	404,211	33
	B. Capital Expense		
34	Ownership	106,945	34
	C. Ancillary Expense		
35	Special Cost Centers	69,836	35
36	Provider Participation Fee	117,293	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,856,505	40
41	Income before Income Taxes (line 30 minus line 40)**	252,810	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 252,810	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,158,670	44
45	Private Pay - Net Inpatient Revenue	625,400	45
46	Medicare - Net Inpatient Revenue	116,529	46
47	Other-(specify) <u>Insurance Net Inpatient Revenue</u>	32,394	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 1,932,993	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	998	1,107	\$ 22,481	\$ 20.31	1
2	Assistant Director of Nursing					2
3	Registered Nurses	206	206	5,461	26.51	3
4	Licensed Practical Nurses	9,859	10,223	227,449	22.25	4
5	CNAs & Orderlies	24,038	24,947	285,357	11.44	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,482	1,482	18,346	12.38	9
10	Activity Assistants	28	28	287	10.25	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	40,437	19.44	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,512	7,630	74,660	9.79	15
16	Dishwashers					16
17	Maintenance Workers	2,080	2,080	29,810	14.33	17
18	Housekeepers	6,227	7,517	62,754	8.35	18
19	Laundry	930	1,000	8,148	8.15	19
20	Administrator	2,080	2,080	69,417	33.37	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,791	2,871	35,824	12.48	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>See PG20A</u>	3,884	3,932	55,535	14.12	33
34	TOTAL (lines 1 - 33)	64,195	67,183	\$ 935,966 *	\$ 13.93	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	5	\$ 323	L1, C3	35
36	Medical Director	Monthly	12,000	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,727	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	2	116	L10A, C3	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	7	\$ 15,165		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	37	\$ 1,170	L10, C3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	37	\$ 1,170		53

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

** See instructions.

Shelbyville Reh & Hlth C Ctr
0053066
Period Beginning 1/1/2016
Period End 12/31/2016

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	906	906	15,767	17.40
Transportation	1,040	1,040	8,875	8.53
Marketing	1,938	1,986	30,893	15.56
TOTAL	3,884	3,932	55,535	

STATE OF ILLINOIS

0053066

Report Period Beginning:

1/1/2016

Page 21

Ending: 12/31/2016

Facility Name & ID Number

Shelbyville Reh & Hlth C Ctr

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		
Susan Shaw		Administrator	0	\$ 41,000	Workers' Compensation Insurance		\$ 27,072	IDPH License Fee		\$ 3,980		
Valerie Tischler		Administrator	0	28,417	Unemployment Compensation Insurance		24,721	Advertising: Employee Recruitment		597		
					FICA Taxes		64,812	Health Care Worker Background Check				
					Employee Health Insurance		4,018	(Indicate # of checks performed 60)		675		
					Employee Meals			Patient Background Checks		101		
					Illinois Municipal Retirement Fund (IMRF)*			Miscellaneous Licenses & Permits		587		
					Employee Relations		3,602	Miscellaneous Dues & Subscriptions		1,320		
					Home Office Allocation		17,329	Home Office Allocation		283		
TOTAL (agree to Schedule V, line 17, col. 1)												
(List each licensed administrator separately.)				\$ 69,417								
B. Administrative - Other												
Description			Amount									
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 187,600					Less: Public Relations Expense (320)				
								Non-allowable advertising ()				
								Yellow page advertising ()				
				TOTAL (agree to Schedule V, line 22, col.8)			\$ 141,554	TOTAL (agree to Sch. V, line 20, col. 8)			\$ 7,223	
TOTAL (agree to Schedule V, line 17, col. 3)				\$ 187,600	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		
E-Health Data Solutions		Computer Services	\$ 3,042					Out-of-State Travel		\$		
Consolidated Communications		Computer Services	1,139									
Honkamp Krueger & Co.		Accounting Services	348	N/A								
Allscripts		Computer Services	960					In-State Travel				
								Seminar Expense				
								Home Office Allocation		29		
								Entertainment Expense ()				
								(agree to Sch. V, line 24, col. 8)				
								TOTAL		\$ 29		
TOTAL (agree to Schedule V, line 19, column 3)				\$ 5,489	TOTAL							
(For legal fee disclosure, see page 39 of instructions)												

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

Shelbyville Reh & Hlth C Ctr
0053066
Period Beginning1/1/2016
Period End12/31/2016

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		5,489
Home Office Allocation		
Lucie, Scalf, and Bougher	Legal	30
Miscellaneous	Legal	15
Miller Hall and Triggs	Legal	52
Healthcare Resources International	Legal	261
Hunziker Law	Legal	62
Lexis Nexis	Legal	5
Gemino	Legal	4,701
Illinois Secretary of State	Legal	34
Peoria County Recorder	Legal	14
CliftonLarson Allen	Accountants	271
Ginoli & Co.	Accountants	2,756
Miscellaneous	Computer Services	34
Change Healthcare	Computer Services	5
PTC Select	Computer Services	3
Advanced Answers on Demand	Computer Services	2,383
Stratus Networks	Computer Services	242
Kemper Technology	Computer Services	160
AT&T	Computer Services	3
Ability Network	Computer Services	1,016
CIAN	Computer Services	121
Comcast	Computer Services	20
CCH	Computer Services	8
Charter Communications	Computer Services	24
Allscripts	Computer Services	354
ATS	Computer Services	160
Allpayer Exchange	Computer Services	8
Optimizer	Other Prof Fees	24
Ankura	Other Prof Fees	185
David Budde	Other Prof Fees	21
Bruner, Cooper, Zuck	Other Prof Fees	54
Marotta, Gund, Budd, Dzerda	Other Prof Fees	4,150
Professional Software and Services	Other Prof Fees	13
Hughes Valuation Services	Other Prof Fees	17
Alan Litwiller	Other Prof Fees	1

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

22,696

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. \$ 10,854 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. \$ 117,293
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. \$ 1,859

(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. \$ 2,272
c. What percent of all travel expense relates to transportation of nurses and patients? 100
d. Have vehicle usage logs been maintained? Adequate records have been maintained.
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A

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

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

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

RECONCILIATION REPORT			Shelbyville Reh & Hlth C		12:08 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	-51,879	equal to	-51,879	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	27,544	equal to	27,544	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	32,504	equal to	32,504	0	FAILED	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	18,277	equal to	18,277	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	58,668	equal to	58,668	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	25,486	equal to	25,486	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	76,866	equal to	76,866	0	O.K.	Pg16 Z12+Z14..	N/A,B	1-4,40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv.- Supplies	15,409	equal to	15,409	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	420,759	equal to	420,759	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	737,461	equal to	737,461	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	404,211	equal to	404,211	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	106,945	equal to	106,945	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	69,836	equal to	69,836	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..,H24+I	N/A	38to41+43	4
Income Stat. Prov. Partic.	117,293	equal to	117,293	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	556,515	equal to	556,515	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	27,508	equal to	27,508	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	0	equal to		#VALUE!	#VALUE!	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	115,097	equal to	115,097	0	O.K.	Pg20 K22..,K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	29,810	equal to	29,810	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	62,754	equal to	62,754	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	8,148	equal to	8,148	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	69,417	equal to	69,417	0	O.K.	Pg20 K30..,K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	35,824	equal to	35,824	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	935,966	equal to	866,549	69,417	FAILED	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	323	< or = to	323	0	O.K.	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	4,012	< or = to	4,441	-429	O.K.	Pg20 X14..,X16+	B. & C.	7to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to	567	-567	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.	69,417	equal to	69,417	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	187,600	equal to	187,600	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	5,489	equal to	5,489	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	141,554	equal to	141,554	0	FAILED	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched. of dues..	7,223	equal to	7,223	0	FAILED	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	29	equal to	29	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	117,293	equal to	117,293	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	538	equal to	609	-71	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	8,370	equal to	8,370	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4I	B.	14	8
Total loan balance	0	equal to	0	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27.	N/A	29+39-41	2
Real estate tax accrual	32,808	equal to	32,808	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	47,250	equal to	47,250	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	999,048	equal to	999,048	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	248,453	equal to	248,453	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	676,550	equal to	676,550	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	300,680	equal to	300,680	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	252,810	equal to	252,810	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	894,732	equal to	894,732	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	115,097	10,933	323	126,353	0	126,353	2,658	129,011
2. Food Purchase	0	87,352	0	87,352	0	87,352	-1,811	85,541
3. Housekeeping	62,754	11,470	0	74,224	0	74,224	46	74,270
4. Laundry	8,148	5,802	0	13,950	0	13,950	0	13,950
5. Heat and Other Utilities	0	0	61,822	61,822	0	61,822	155	61,977
6. Maintenance	29,810	8,784	18,464	57,058	0	57,058	1,451	58,509
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	215,809	124,341	80,609	420,759	0	420,759	2,499	423,258
9. Medical Director	0	0	12,000	12,000	0	12,000	0	12,000
10. Nursing & Medical Records	556,515	58,906	4,441	619,862	0	619,862	-3,300	616,562
10a. Therapy	0	0	76,866	76,866	0	76,866	0	76,866
11. Activities	27,508	616	567	28,691	0	28,691	-2,272	26,419
12. Social Services	0	42	0	42	0	42	0	42
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	584,023	59,564	93,874	737,461	0	737,461	-5,572	731,889
17. Administrative	0	0	187,600	187,600	0	187,600	-118,183	69,417
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	5,489	5,489	0	5,489	17,205	22,694
20. Fees, Subscriptions & Promotion	0	0	7,260	7,260	0	7,260	-37	7,223
21. Clerical & General Office	35,824	1,684	11,102	48,610	0	48,610	30,904	79,514
22. Employee Benefits & Payroll	0	0	124,225	124,225	0	124,225	17,329	141,554
23. Inservice Training & Education	0	0	0	0	0	0	59	59
24. Travel and Seminar	0	0	0	0	0	0	29	29
25. Other Admin. Staff Trans	0	0	6,537	6,537	0	6,537	2,438	8,975
26. Insurance-Prop.Liab.Malpractice	0	0	24,490	24,490	0	24,490	343	24,833
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	35,824	1,684	366,703	404,211	0	404,211	-49,913	354,298
29. Total General Administrative	835,656	185,589	541,186	1,562,431	0	1,562,431	-52,986	#####
30. Depreciation	0	0	49,671	49,671	0	49,671	8,997	58,668
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	18,277	18,277
32. Interest	0	0	0	0	0	0	27,544	27,544
33. Real Estate	0	0	32,346	32,346	0	32,346	158	32,504
34. Rent - Facility & Grounds	0	0	0	0	0	0	0	0
35. Rent - Equipment & Vehicles	0	0	24,928	24,928	0	24,928	558	25,486
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	106,945	106,945	0	106,945	55,534	162,479
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	15,409	0	15,409	0	15,409	0	15,409
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	117,293	117,293	0	117,293	0	117,293
43. Other (specify):*	30,893	594	22,940	54,427	0	54,427	-54,427	0
44. Total Special Cost Ce	30,893	16,003	140,233	187,129	0	187,129	-54,427	132,702
45. Grand Total	866,549	201,592	788,364	1,856,505	0	1,856,505	-51,879	#####

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	-250,515	-250,515
2. Cash - Patient Deposits	161	161
3. Accounts & Notes Recievable	498,099	498,099
4. Supply Inventory	6,592	6,592
5. Short-Term Investments	0	0
6. Prepaid Insurance	23,137	23,137
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	495	495
10. Total current assets	277,969	277,969
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	68,615	47,250
14. Buildings, at Historical Cost	855,750	861,464
15. Leasehold Improvements, Historical Cost	109,083	137,584
16. Equipment, at Historical Cost	248,453	248,453
17. Accumulated Depreciation (book methods)	-667,931	-676,550
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):	2,793	2,793
24. Total Long-Term Assets	616,763	620,994
25. Total Assets	894,732	898,963
CURRENT LIABILITIES		
26. Accounts Payable	291,911	291,911
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	43,351	43,351
31. Accrued Taxes Payable	22,512	22,512
32. Accrued Real Estate Taxes	32,808	32,808
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	61,835	61,835
37. Other Current Liabilities (specify):	141,635	141,635
38. Total Current Liabilities	594,052	594,052
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	0
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	0	0
46.Total Liabilities	594,052	594,052
47.Total Equity	300,680	304,911
48.Total Liabilities and Equity	894,732	898,963

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	1,989,270
2. Discounts and Allowances for all Levels	-56,277
Subtotal - Inpatient Care	1,932,993
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	135,295
7. Oxygen	263
Subtotal - Ancillary Revenue	135,558
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	1,859
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	27,239
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiology and X-Ray	2,989
21. Other Medical Services	2,895
22. Laundry	0
Subtotal - Other Operating Revenue	34,982
24. Contributions	0
25. Interest and Other Investments Income	44
Subtotal - Non-Operating Revenue	44
27. Other Revenue (specify):	2,272
28. Other Revenue (specify):	3,466
Subtotal - Other Revenue	5,738
30. Total Revenue	2,109,315
31. General Services	409,638
32. Health Care	694,827
33. General Administration	400,637
34. Ownership	111,000
35. Special Cost Centers	100,297
35. Provider Participation Fee	112,071
37. Other	0
40. Total Expenses	1,828,470
41. Income Before Income Taxes	280,845
42. Income Taxes	0
43. Net Income or Loss for the Year	280,845