

		FOR BHF USE					

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**2014**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2014)**

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.

<p><b>I. IDPH License ID Number:</b> <u>0053157</u></p> <p><b>Facility Name:</b> <u>Enfield Rehab &amp; Hlth Care Ct</u></p> <p><b>Address:</b> <u>408 North Wilson St</u> <u>Enfield</u> <u>62835</u>        Number City Zip Code</p> <p><b>County:</b> <u>White</u></p> <p><b>Telephone Number:</b> <u>(618) 963-2331</u> <b>Fax #</b> <u>(618) 963-2083</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>10/01/2005</u></p> <p><b>Type of Ownership:</b></p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Mike Kocher</u> <b>Telephone Number:</b> <u>(309)689-5850</u>  <b>Email Address:</b> _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/14</u> to <u>12/31/14</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Mark B. Petersen</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>Chief Executive Officer</u></td> <td></td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> <td></td> </tr> <tr> <td>(Firm Name &amp; Address) _____</td> <td></td> </tr> <tr> <td>(Telephone) <u>( )</u> <b>Fax #</b> <u>( )</u></td> <td></td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) <u>Mark B. Petersen</u>			(Title) <u>Chief Executive Officer</u>		Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) <u>( )</u> <b>Fax #</b> <u>( )</u>	
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	<p><b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>  <b>201 S. Grand Avenue East</b>  <b>Springfield, IL 62763-0001</b> <b>Phone # (217) 782-1630</b></p>																																									

Facility Name & ID Number Enfield Rehab & Hlth Care Ct

# 0053157 Report Period Beginning: 1/1/14 Ending: 12/31/14

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>23</u>	Skilled (SNF)	<u>23</u>	<u>8,395</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>24</u>	Intermediate (ICF)	<u>24</u>	<u>8,760</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>47</u>	TOTALS	<u>47</u>	<u>17,155</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			<u>888</u>	<u>888</u>	8
9	SNF/PED					9
10	ICF	<u>5,493</u>	<u>1,925</u>	<u>19</u>	<u>7,437</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>5,493</u>	<u>1,925</u>	<u>907</u>	<u>8,325</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 48.53%

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 23 and days of care provided 888

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: 12/31/14 Fiscal Year: 12/31/14

\* All facilities other than governmental must report on the accrual basis.

**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
	<b>A. General Services</b>										
1	Dietary	84,070	5,169		89,239		89,239	2,814	92,053		1
2	Food Purchase		58,535		58,535		58,535	(860)	57,675		2
3	Housekeeping	46,242	12,413		58,655		58,655	17	58,672		3
4	Laundry	437	773		1,210		1,210		1,210		4
5	Heat and Other Utilities			37,292	37,292		37,292	106	37,398		5
6	Maintenance	24,776	6,905	13,566	45,247		45,247	1,058	46,305		6
7	Other (specify):* Home Off. Ben. All.										7
8	<b>TOTAL General Services</b>	155,525	83,795	50,858	290,178		290,178	3,135	293,313		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			6,000	6,000		6,000	10	6,010		9
10	Nursing and Medical Records	411,630	36,934	1,568	450,132		450,132	(531)	449,601		10
10a	Therapy			71,544	71,544		71,544		71,544		10a
11	Activities	19,353	41	306	19,700		19,700	(10,322)	9,378		11
12	Social Services	25,626	102		25,728		25,728		25,728		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.										15
16	<b>TOTAL Health Care and Programs</b>	456,609	37,077	79,418	573,104		573,104	(10,843)	562,261		16
	<b>C. General Administration</b>										
17	Administrative			118,800	118,800		118,800	(64,800)	54,000		17
18	Directors Fees										18
19	Professional Services			17,949	17,949		17,949	35,884	53,833		19
20	Dues, Fees, Subscriptions & Promotions			3,865	3,865		3,865	148	4,013		20
21	Clerical & General Office Expenses	4,807	2,171	7,025	14,003		14,003	31,126	45,129		21
22	Employee Benefits & Payroll Taxes			92,385	92,385		92,385	7,387	99,772		22
23	Inservice Training & Education							13	13		23
24	Travel and Seminar							11	11		24
25	Other Admin. Staff Transportation			8,740	8,740		8,740	1,709	10,449		25
26	Insurance-Prop.Liab.Malpractice			17,744	17,744		17,744	247	17,991		26
27	Other (specify):* Home Off. Ben. All.										27
28	<b>TOTAL General Administration</b>	4,807	2,171	266,508	273,486		273,486	11,725	285,211		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	616,941	123,043	396,784	1,136,768		1,136,768	4,017	1,140,785		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.

Facility Name &amp; ID Number

Enfield Rehab &amp; Hlth Care Ct

#0053157

Report Period Beginning:

1/1/14

Ending:

12/31/14

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	<b>D. Ownership</b>											
30	Depreciation			18,486	18,486	18,486	2,167	20,653				30
31	Amortization of Pre-Op. & Org.						372	372				31
32	Interest			4,403	4,403	4,403	7,833	12,236				32
33	Real Estate Taxes			6,593	6,593	6,593	98	6,691				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			21,326	21,326	21,326	416	21,742				35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			50,808	50,808	50,808	10,886	61,694				37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		15,708		15,708	15,708		15,708				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			73,086	73,086	73,086		73,086				42
43	Other (specify):*		440	59,879	60,319	60,319	(60,319)					43
44	<b>TOTAL Special Cost Centers</b>		16,148	132,965	149,113	149,113	(60,319)	88,794				44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	616,941	139,191	580,557	1,336,689	1,336,689	(45,416)	1,291,273				45

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

Facility Name & ID Number Enfield Rehab & Hlth Care Ct

# 0053157

Report Period Beginning: 1/1/14

Ending: 12/31/14

**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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(893)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,943)	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	71	30		9
10	Interest and Other Investment Income	(11)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(60)	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	(28,382)	43		18
19	Entertainment				19
20	Contributions	(50)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(23,999)	43		24
25	Fund Raising, Advertising and Promotional	(1,212)	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	(13,634)	Various		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (72,113)		\$	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	2	
		Amount	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)	26,697	Various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 26,697		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (45,416)		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	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

Enfield Rehab & Hlth Care Ct

ID# 0053157

Report Period Beginning: 1/1/14

Ending: 12/31/14

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Offset Miscellaneous Nursing Supplies Revenue	\$ (539)	10	1
2	Resident Flowers	(122)	43	2
3	Offset Transportation Revenue	(10,322)	11	3
4	Disallow Special events	102	43	4
5	X-Rays Part A	(857)	43	5
6	Labs Part A	(1,796)	43	6
7	Offset Miscellaneous Nursing Supplies Revenue	(100)	21	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
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31				31
32				32

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34				34
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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	<b>Total</b>		(13,634)	49

**VII. RELATED PARTIES**

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

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

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 1,226	\$ 1,226	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	29	29	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	6	6	3
4	V	5 Utilities		Petersen Health Care, Inc.	100.00%	83	83	4
5	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	465	465	5
6	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		6
7	V	9 Medical Director		Petersen Health Care, Inc.	100.00%	10	10	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	0		8
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		10
11	V	17 Administrative		Petersen Health Care, Inc.	100.00%	0		11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	1,057	1,057	12
13	V							13
14	Total		\$			\$ 2,876	\$ * 2,876	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 &amp; Promotions</u>	\$	<u>Petersen Health Care, Inc.</u>	100.00%	\$ 59	\$	59	15
16	V	21 <u>Clerical and General Office</u>		<u>Petersen Health Care, Inc.</u>	100.00%	13,796		13,796	16
17	V	22 <u>Employee Benefits and Payroll Taxes</u>		<u>Petersen Health Care, Inc.</u>	100.00%	627		627	17
18	V	23 <u>Inservice Training &amp; Education</u>		<u>Petersen Health Care, Inc.</u>	100.00%	7		7	18
19	V	24 <u>Travel and Seminar</u>		<u>Petersen Health Care, Inc.</u>	100.00%	4		4	19
20	V	25 <u>Other Admin. Staff Transport.</u>		<u>Petersen Health Care, Inc.</u>	100.00%	1,116		1,116	20
21	V	26 <u>Insurance-Prop./Liab./Malprac.</u>		<u>Petersen Health Care, Inc.</u>	100.00%	197		197	21
22	V	27 <u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0		0	22
23	V	30 <u>Depreciation</u>		<u>Petersen Health Care, Inc.</u>	100.00%	1,127		1,127	23
24	V	32 <u>Interest</u>		<u>Petersen Health Care, Inc.</u>	100.00%	717		717	24
25	V	33 <u>Real Estate Taxes</u>		<u>Petersen Health Care, Inc.</u>	100.00%	55		55	25
26	V	35 <u>Rent-Equipment &amp; Vehicles</u>		<u>Petersen Health Care, Inc.</u>	100.00%	283		283	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	<b>Total</b>		\$			\$ 17,988	\$ *	17,988	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 Operations, LLC	100.00%	\$ 0	\$	15
16	V	2 Food		Petersen Health Operations, LLC	100.00%	0		16
17	V	3 Housekeeping		Petersen Health Operations, LLC	100.00%	0		17
18	V	4 Laundry		Petersen Health Operations, LLC	100.00%	0		18
19	V	5 Utilities		Petersen Health Operations, LLC	100.00%	0		19
20	V	6 Maintenance		Petersen Health Operations, LLC	100.00%	0		20
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	0		21
22	V	10 Nursing and Medical Records		Petersen Health Operations, LLC	100.00%	0		22
23	V	12 Social Services		Petersen Health Operations, LLC	100.00%	0		23
24	V	17 Administrative		Petersen Health Operations, LLC	100.00%	0		24
25	V	19 Professional Services		Petersen Health Operations, LLC	100.00%	32,439	32,439	25
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Operations, LLC	100.00%	70	70	26
27	V	21 Clerical and General Office		Petersen Health Operations, LLC	100.00%	0		27
28	V	22 Employee Benefits & Payroll		Petersen Health Operations, LLC	100.00%	747	747	28
29	V	23 Inservice Training & Education		Petersen Health Operations, LLC	100.00%	0		29
30	V	24 Travel and Seminar		Petersen Health Operations, LLC	100.00%	0		30
31	V	25 Other Admin. Staff Transport.		Petersen Health Operations, LLC	100.00%	0		31
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Operations, LLC	100.00%	0		32
33	V	27 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	0		33
34	V	30 Depreciation		Petersen Health Operations, LLC	100.00%	893	893	34
35	V	32 Interest		Petersen Health Operations, LLC	100.00%	3,730	3,730	35
36	V	33 Real Estate Taxes		Petersen Health Operations, LLC	100.00%	0		36
37	V	34 Rent-Facility and Grounds		Petersen Health Operations, LLC	100.00%	0		37
38	V	35 Rent-Equipment & Vehicles		Petersen Health Operations, LLC	100.00%	0		38
39	Total		\$			\$ 37,879	\$ * 37,879	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 Care Management, Inc.	100.00%	\$ 1,588	\$ 1,588
16	V	2 Food		Petersen Health Care Management, Inc.	100.00%	4	4
17	V	3 Housekeeping		Petersen Health Care Management, Inc.	100.00%	11	11
18	V	5 Utilities		Petersen Health Care Management, Inc.	100.00%	23	23
19	V	6 Maintenance		Petersen Health Care Management, Inc.	100.00%	593	593
20	V	7 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0	0
21	V	9 Medical Director		Petersen Health Care Management, Inc.	100.00%	0	0
22	V	10 Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	8	8
23	V	10A Therapy		Petersen Health Care Management, Inc.	100.00%	0	0
24	V	15 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0	0
25	V	17 Administrative	118,800	Petersen Health Care Management, Inc.	100.00%	54,000	(64,800)
26	V	19 Professional Services		Petersen Health Care Management, Inc.	100.00%	2,388	2,388
27	V	20 Dues, Fees, Subs & Promotions		Petersen Health Care Management, Inc.	100.00%	19	19
28	V	21 Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	17,430	17,430
29	V	22 Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	6,013	6,013
30	V	23 Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	6	6
31	V	24 Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	7	7
32	V	25 Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	593	593
33	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	50	50
34	V	27 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0	0
35	V	30 Depreciation		Petersen Health Care Management, Inc.	100.00%	76	76
36	V	32 Interest		Petersen Health Care Management, Inc.	100.00%	101	101
37	V	33 Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	43	43
38	V	35 Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	133	133
39	Total		\$ 118,800			\$ 83,086	\$ * (35,714)

\* 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	5 Utilities		Petersen Health & Wellness, LLC	100.00%	0		18
19	V	6 Maintenance		Petersen Health & Wellness, LLC	100.00%	0		19
20	V	7 Mgmt. Allocation of Benefits		Petersen Health & Wellness, LLC	100.00%	0		20
21	V	9 Medical Director		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	10A Therapy		Petersen Health & Wellness, LLC	100.00%	0		23
24	V	15 Mgmt. Allocation of Benefits		Petersen Health & Wellness, LLC	100.00%	0		24
25	V	17 Administrative		Petersen Health & Wellness, LLC	100.00%	0		25
26	V	19 Professional Services		Petersen Health & Wellness, LLC	100.00%	0		26
27	V	20 Dues, Fees, Subs & Promotions		Petersen Health & Wellness, LLC	100.00%	0		27
28	V	21 Clerical and General Office		Petersen Health & Wellness, LLC	100.00%	0		28
29	V	22 Employee Benefits and Payroll Taxes		Petersen Health & Wellness, LLC	100.00%	0		29
30	V	23 Inservice Training & Education		Petersen Health & Wellness, LLC	100.00%	0		30
31	V	24 Travel and Seminar		Petersen Health & Wellness, LLC	100.00%	0		31
32	V	25 Other Admin. Staff Transport.		Petersen Health & Wellness, LLC	100.00%	0		32
33	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health & Wellness, LLC	100.00%	0		33
34	V	27 Mgmt. Allocation of Benefits		Petersen Health & Wellness, LLC	100.00%	0		34
35	V	30 Depreciation		Petersen Health & Wellness, LLC	100.00%	0		35
36	V	31 Amortization of Pre-Op. & Org.		Petersen Health & Wellness, LLC	100.00%	372		372 36
37	V	32 Interest		Petersen Health & Wellness, LLC	100.00%	3,296		3,296 37
38	V	33 Real Estate Taxes		Petersen Health & Wellness, LLC	100.00%	0		0 38
39	Total		\$			\$ 3,668	\$ *	3,668 39

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

Facility Name &amp; ID Number

Enfield Rehab &amp; Hlth Care Ct

# 0053157

Report Period Beginning:

1/1/14

Ending:

12/31/14

## 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 J	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 Restaurants,	Peoria	Restaurant	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Health Care	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Care	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	Mgmt/Bookkeeping	13
14			Decatur Rehab & Health Care Center	Decatur	Petersen Health Care	Peoria	Lessor	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Osage Beach,	Osage Beach, MO	Lessor	15
16			Eastview Terrace	Sullivan	Petersen West Frankf	West Frankfort	Lessor	16
17			El Paso Health Care Center	El Paso	Midwest Health Care,	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Poplar Bluff Health C	Poplar Bluff, MO	Lessor	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Roseville, LL	Roseville	Lessor	19
20			Flanagan Rehab & Health Care Center	Flanagan	Petersen Health Juncti	Peoria	Mgmt/Bookkeeping	20
21			Flora Gardens Care Center	Flora	Petersen Health Qualit	Peoria	Mgmt/Bookkeeping	21
22			Flora Health Care Center	Flora	Petersen Health and W	Peoria	Mgmt/Bookkeeping	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 &amp; ID Number

Enfield Rehab &amp; Hlth Care Ct

# 0053157

Report Period Beginning:

1/1/14

Ending:

12/31/14

## 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			Orchard View Rehab & Health Care Center	Princeton				7
8			Palm Terrace of Mattoon	Mattoon				8
9			Piper City Rehab & Living Center	Piper City				9
10			Pleasant View Rehab & Health Care Center	Morrison				10
11			Polo Rehabilitation & Health Care Center	Polo				11
12			Prairie City Rehab & Health Care Center	Prairie City				12
13			Robings Manor Nursing Home	Brighton				13
14			Rochelle Gardens	Rochelle				14
15			Rochelle Rehab & Health Care Center	Rochelle				15
16			Rock Falls Rehab & Health Care Center	Rock Falls				16
17			Arrow Wood Independent Living	Rock Falls				17
18			Roseville Rehab and Health Care Center	Roseville				18
19			Rosiclare Rehab & Health Care Center	Rosiclare				19
20			Royal Oaks Care Center	Kewanee				20
21			Sandwich Rehab & Health Care Center	Sandwich				21
22			Iron Wood Independent Living	Sandwich				22
23			Shawnee Rose Care Center	Harrisburg				23
24			Shelbyville Rehab & Health Care Center	Shelbyville				24
25			South Elgin Rehab & Health Care Center	South Elgin				25
26			Sugar Creek Care Center	Watseka				26
27			Sullivan Health Care Center	Sullivan				27
28			Sunset Manor Nursing Home	Canton				28
29			Swansea Rehab & Health Care	Swansea				29
30			Timbercreek Rehab & Health Center	Pekin				30

Facility Name &amp; ID Number

Enfield Rehab &amp; Hlth Care Ct

# 0053157

Report Period Beginning:

1/1/14

Ending:

12/31/14

## 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			Toulon Health Care Center	Toulon				1
2			Tuscola Health Care Center	Tuscola				2
3			Twin Lakes Rehab & Health Care Center	Paris				3
4			Vandalia Rehab & Health Care Center	Vandalia				4
5			Watseka Health Care Center	Watseka				5
6			Westside Rehab & Care Center	West Frankfort				6
7			Whispering Oaks	Rosiclare				7
8			White Oak Rehab & Health Care Center	Mt. Vernon				8
9			Willow Rose Rehab & Health Care Center	Jerseyville				9
10			Sheldon Health Care Center	Sheldon				10
11			Tuscola Health Care Center	Tuscola				11
12			Effingham Health Care Center	Effingham				12
13			Collinsville Health Care Center	Collinsville				13
14			Ozark Rehab & Health Care Center	Osage Beach, MO				14
15			South Shore Health Care, LLC	Gary, IN				15
16			Cedargate Skilled Nursing Facility	Poplar Bluff, MO				16
17			Tarkio Rehab & Health Care Center	Tarkio, MO				17
18			Shangri-la Rehab & Living Center	Blue Springs, MO				18
19			Prairie Rose Care Center	Pana				19
20			Illini Heritage Rehab & Health Center	Champaign				20
21			Courtyard Estates of Kewanee	Kewanee				21
22			Courtyard Estates of Bradford	Bradford				22
23			Courtyard Estates of Galva	Galva				23
24			Courtyard Estates of Walcott	Walcott				24
25			Courtyard Village of Kewanee	Kewanee				25
26			Lakewood Village	Charleston				26
27			Courtyard Estates of Monmouth	Monmouth				27
28			Riverview Estates	Havana				28
29			Simple Blessings	Casey				29
30			Courtyard Estates of Bushnell	Bushnell				30

Facility Name & ID Number

Enfield Rehab & Hlth Care Ct

# 0053157

Report Period Beginning:

1/1/14

Ending:

12/31/14

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			Courtyard Estates of Canton	Canton				1
2			Legacy Estates of Monmouth	Monmouth				2
3			Courtyard Estates of Sullivan	Sullivan				3
4			Courtyard Estates of Peoria	Peoria				4
5			Cornerstone Health and Rehabilitation	Peoria				5
6			Rock River Gardens	Peoria				6
7			Sauk Valley Senior Living & Rehabilitation	Peoria				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 Enfield Rehab & Hlth Care Ct # 0053157 Report Period Beginning: 1/1/14 Ending: 12/31/14

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										3
4										4
5										5
6	N/A									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 Enfield Rehab & Hlth Care Ct

# 0053157

Report Period Beginning:

1/1/14

Ending: 12/31/14

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

Name of Related Organization Petersen Health Care, Inc.  
 Street Address 830 W. Trailcreek Drive  
 City / State / Zip Code Peoria, IL 61614  
 Phone Number (309) 691-8113  
 Fax Number (309) 691-8622

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

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	1,572,338	77	\$ 231,473	\$ 220,289	8,325	\$ 1,226	1
2	2	Food	Resident Days	1,572,338	77	5,537	0	8,325	29	2
3	3	Housekeeping	Resident Days	1,572,338	77	1,187	0	8,325	6	3
4	5	Utilities	Resident Days	1,572,338	77	15,618	0	8,325	83	4
5	6	Maintenance	Resident Days	1,572,338	77	87,839	72,289	8,325	465	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77	0	0	8,325	0	6
7	9	Medical Director	Resident Days	1,572,338	77	1,878	0	8,325	10	7
8	10	Nursing and Medical Records	Resident Days	1,572,338	77	71	0	8,325	0	8
9	10A	Therapy	Resident Days	1,572,338	77	0	0	8,325	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77	0	0	8,325	0	10
11	17	Administrative	Resident Days	1,572,338	77	0	0	8,325	0	11
12	19	Professional Services	Resident Days	1,572,338	77	199,631	0	8,325	1,057	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,572,338	77	11,115	0	8,325	59	13
14	21	Clerical and General Office	Resident Days	1,572,338	77	2,605,685	2,406,945	8,325	13,796	14
15	22	Employee Benefits and Payroll Tax	Resident Days	1,572,338	77	118,476	0	8,325	627	15
16	23	Inservice Training & Education	Resident Days	1,572,338	77	1,316	0	8,325	7	16
17	24	Travel and Seminar	Resident Days	1,572,338	77	811	0	8,325	4	17
18	25	Other Admin. Staff Transport.	Resident Days	1,572,338	77	210,720	0	8,325	1,116	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,572,338	77	37,141	0	8,325	197	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77	0	0	8,325	0	20
21	30	Depreciation	Resident Days	1,572,338	77	212,800	0	8,325	1,127	21
22	32	Interest	Resident Days	1,572,338	77	135,328	0	8,325	717	22
23	33	Real Estate Taxes	Resident Days	1,572,338	77	10,451	0	8,325	55	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,572,338	77	53,540	0	8,325	283	24
25	TOTALS					\$ 3,940,617	\$ 2,699,523		\$ 20,864	25

Facility Name & ID Number Enfield Rehab & Hlth Care Ct

# 0053157

Report Period Beginning:

1/1/14

Ending: 12/31/14

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 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	314,070	19		8,325		1
2	2	Food	Resident Days	314,070	19		8,325		2
3	3	Housekeeping	Resident Days	314,070	19		8,325		3
4	4	Laundry	Resident Days	314,070	19		8,325		4
5	5	Utilities	Resident Days	314,070	19		8,325		5
6	6	Maintenance	Resident Days	314,070	19		8,325		6
7	7	Mgmt. Allocation of Benefits	Resident Days	314,070	19		8,325		7
8	10	Nursing and Medical Records	Resident Days	314,070	19		8,325		8
9	12	Social Services	Resident Days	314,070	19		8,325		9
10	17	Administrative	Resident Days	314,070	19		8,325		10
11	19	Professional Services	Resident Days	314,070	19	1,618,178	8,325	32,439	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	314,070	19	3,514	8,325	70	12
13	21	Clerical and General Office	Resident Days	314,070	19		8,325		13
14	22	Employee Benefits & Payroll	Resident Days	314,070	19	37,245	8,325	747	14
15	23	Inservice Training & Education	Resident Days	314,070	19		8,325		15
16	24	Travel and Seminar	Resident Days	314,070	19		8,325		16
17	25	Other Admin. Staff Transport.	Resident Days	314,070	19		8,325		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	314,070	19		8,325		18
19	27	Mgmt. Allocation of Benefits	Resident Days	314,070	19		8,325		19
20	30	Depreciation	Resident Days	314,070	19	44,535	8,325	893	20
21	32	Interest	Resident Days	314,070	19	186,049	8,325	3,730	21
22	33	Real Estate Taxes	Resident Days	314,070	19		8,325		22
23	34	Rent-Facility and Grounds	Resident Days	314,070	19		8,325		23
24	35	Rent-Equipment & Vehicles	Resident Days	314,070	19		8,325		24
25	TOTALS					\$ 1,889,521	\$	\$ 37,879	25

Facility Name & ID Number Enfield Rehab & Hlth Care Ct

# 0053157

Report Period Beginning:

1/1/14

Ending: 12/31/14

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

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

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

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	1,572,338	77	\$ 299,961	\$ 294,997	8,325	\$ 1,588	1
2	2	Food	Resident Days	1,572,338	77	675		8,325	4	2
3	3	Housekeeping	Resident Days	1,572,338	77	2,074	558	8,325	11	3
4	5	Utilities	Resident Days	1,572,338	77	4,349		8,325	23	4
5	6	Maintenance	Resident Days	1,572,338	77	111,954	94,000	8,325	593	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77			8,325		6
7	9	Medical Director	Resident Days	1,572,338	77			8,325		7
8	10	Nursing and Medical Records	Resident Days	1,572,338	77	1,457		8,325	8	8
9	10A	Therapy	Resident Days	1,572,338	77			8,325		9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77			8,325		10
11	17	Administrative	Resident Days	1,572,338	77	4,576,674	4,576,674	8,325	54,000	11
12	19	Professional Services	Resident Days	1,572,338	77	450,944		8,325	2,388	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,572,338	77	3,620		8,325	19	13
14	21	Clerical and General Office	Resident Days	1,572,338	77	3,292,039	3,146,898	8,325	17,430	14
15	22	Employee Benefits and Payroll Tax	Resident Days	1,572,338	77	1,135,672		8,325	6,013	15
16	23	Inservice Training & Education	Resident Days	1,572,338	77	1,074		8,325	6	16
17	24	Travel and Seminar	Resident Days	1,572,338	77	1,245		8,325	7	17
18	25	Other Admin. Staff Transport.	Resident Days	1,572,338	77	111,953		8,325	593	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,572,338	77	9,420		8,325	50	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77			8,325		20
21	30	Depreciation	Resident Days	1,572,338	77	14,419		8,325	76	21
22	32	Interest	Resident Days	1,572,338	77	19,133		8,325	101	22
23	33	Real Estate Taxes	Resident Days	1,572,338	77	8,076		8,325	43	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,572,338	77	25,085		8,325	133	24
25	TOTALS					\$ 10,069,824	\$ 8,113,127		\$ 83,086	25

Facility Name & ID Number Enfield Rehab & Hlth Care Ct

# 0053157

Report Period Beginning:

1/1/14

Ending: 12/31/14

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 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	43,482	11		8,325		1
2	2	Food	Resident Days	43,482	11		8,325		2
3	3	Housekeeping	Resident Days	43,482	11		8,325		3
4	5	Utilities	Resident Days	43,482	11		8,325		4
5	6	Maintenance	Resident Days	43,482	11		8,325		5
6	7	Mgmt. Allocation of Benefits	Resident Days	43,482	11		8,325		6
7	9	Medical Director	Resident Days	43,482	11		8,325		7
8	10	Nursing and Medical Records	Resident Days	43,482	11		8,325		8
9	10A	Therapy	Resident Days	43,482	11		8,325		9
10	15	Mgmt. Allocation of Benefits	Resident Days	43,482	11		8,325		10
11	17	Administrative	Resident Days	43,482	11		8,325		11
12	19	Professional Services	Resident Days	43,482	11		8,325		12
13	20	Dues, Fees, Subs & Promotions	Resident Days	43,482	11		8,325		13
14	21	Clerical and General Office	Resident Days	43,482	11		8,325		14
15	22	Employee Benefits and Payroll Tax	Resident Days	43,482	11		8,325		15
16	23	Inservice Training & Education	Resident Days	43,482	11		8,325		16
17	24	Travel and Seminar	Resident Days	43,482	11		8,325		17
18	25	Other Admin. Staff Transport.	Resident Days	43,482	11		8,325		18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	43,482	11		8,325		19
20	27	Mgmt. Allocation of Benefits	Resident Days	43,482	11		8,325		20
21	30	Depreciation	Resident Days	43,482	11		8,325		21
22	31	Amortization of Pre-Op. & Org.	Resident Days	43,482	11	7,964	8,325	372	22
23	32	Interest	Resident Days	43,482	11	70,629	8,325	3,296	23
24	33	Real Estate Taxes	Resident Days	43,482	11		8,325		24
25	TOTALS					\$ 78,593	\$	\$ 3,668	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	Name of Lender	2		3	4	5	6		8	9	10	Reporting Period Interest Expense				
		Related**					Monthly Payment Required	Date of Note					Amount of Note		Maturity Date	Interest Rate (4 Digits)
		YES	NO										Original	Balance		
<b>A. Directly Facility Related</b>																
<b>Long-Term</b>																
1	Bank of America		X	Mortgage	Varies	1/19/07	\$ 200,000	\$ 89,186	12/31/14	Varies	\$ 4,403	1				
2												2				
3												3				
4									Interest Income Offset			(11)				
5												5				
<b>Working Capital</b>																
6												6				
7												7				
8												8				
9	<b>TOTAL Facility Related</b>						\$ 200,000	\$ 89,186			\$ 4,392	9				
<b>B. Non-Facility Related*</b>																
10									Home Office Allocation-PHC		717	10				
11									Home Office Allocation-PHO		3,730	11				
12									Home Office Allocation-PHCM		101	12				
13									Home Office Allocation-PHW		3,296	13				
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ 7,844	14				
15	<b>TOTALS (line 9+line14)</b>						\$ 200,000	\$ 89,186			\$ 12,236	15				

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

\* 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.)

Facility Name & ID Number Enfield Rehab & Hlth Care Ct# 0053157

Report Period Beginning:

1/1/14

Ending:

12/31/14**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>				
1. Real Estate Tax accrual used on 2013 report.				\$	<b>7,008</b>	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.)		2013		\$	<b>6,701</b>	2
3. Under or (over) accrual (line 2 minus line 1).				\$	<b>(307)</b>	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	<b>6,900</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>				\$		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.						
					<b>Home Office Allocation</b>	<b>98</b>
<b>TOTAL REFUND</b>	\$	<b>For</b>	<b>Tax Year.</b>			
				\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	<b>6,691</b>	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2009	<u>6,099</u>	<u>8</u>	<b>FOR BHF USE ONLY</b>		
	2010	<u>6,482</u>	<u>9</u>	<b>13</b>	FROM R. E. TAX STATEMENT FOR 2013	<b>13</b>
	2011	<u>6,561</u>	<u>10</u>	<b>14</b>	PLUS APPEAL COST FROM LINE 5	<b>14</b>
	2012	<u>6,802</u>	<u>11</u>	<b>15</b>	LESS REFUND FROM LINE 6	<b>15</b>
	2013	<u>6,701</u>	<u>12</u>	<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	<b>16</b>
<b>Accrual based on prior year tax bill.</b>						

**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.**

# 2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Enfield Rehab & Hlth Care Ct COUNTY White

FACILITY IDPH LICENSE NUMBER 0053157

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

TELEPHONE (309) 691-8113 FAX #: (309) 691-8622

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

Enter the tax index number and real estate tax assessed for 2013 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 2013.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>EN-10-170-5</u>	<u>Long-Term Care Facility</u>	\$ <u>6,701.16</u>	\$ <u>6,701.16</u>
2.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
		<b>TOTALS</b>	\$ <u><u>6,701.16</u></u>	\$ <u><u>6,701.16</u></u>

**B. Real Estate Tax Cost Allocations**



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

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

C. **Tax Bills**

Attach a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

**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.**

Facility Name & ID Number Enfield Rehab & Hlth Care Ct

# 0053157 Report Period Beginning:

1/1/14 Ending:

12/31/14

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 10,476 B. General Construction Type: Exterior Brick & Concrete 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: 99,556 2. Number of Years Over Which it is Being Amortized: 20  
 3. Current Period Amortization: 372 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Facility</u>	<u>75,359</u>	<u>2005</u>	<u>\$ 15,750</u>	1
2					2
3	<b>TOTALS</b>	<u>75,359</u>		<u>\$ 15,750</u>	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	49	2005	1972	\$ 280,250	\$	25	\$ 11,209	\$ 11,209	\$ 106,487
5									
6									
7									
8									
<b>Improvement Type**</b>									
9	Original Land	2005		10,000		15	667	667	6,336
10	Door Alarm	2007		1,636		15	109	109	818
11	Air Compressor	2007		1,302		15	87	87	652
12	New Roof	2007		29,725		20	1,486	1,486	11,145
13	Awning	2008		2,569		20	128	128	832
14	Sprinkler System	2011		2,990		7	428	428	1,498
15	Sidewalk and Pavement Replacement	2013		35,360		25	1,414	1,414	2,121
16	Ceramic and vinyl tile installment-Main Hallways	2014		20,489		15	797	797	797
17	Water Heater	2014		14,671		7	1,223	1,223	1,223
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
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 Enfield Rehab & Hlth Care Ct

# 0053157

Report Period Beginning:

1/1/14

Ending:

12/31/14

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9					
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation					
37		\$	\$		\$	\$	\$	37				
38								38				
39								39				
40								40				
41								41				
42								42				
43								43				
44								44				
45								45				
46								46				
47								47				
48								48				
49								49				
50								50				
51								51				
52								52				
53								53				
54								54				
55								55				
56								56				
57								57				
58								58				
59								59				
60								60				
61								61				
62								62				
63					667		(667)	63				
64					11,253		(11,253)	64				
65					4,752		(4,752)	65				
66								66				
67			3,886			93	93	67				
68			363			20	20	68				
69								69				
70		\$	403,241	\$	16,672	\$	17,661	\$	989	\$	131,909	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	\$ 31,917	\$ 1,814	\$ 2,992	\$ 1,178	5-10 yrs.	\$ 19,117	71
72	Current Year Purchases					10 yrs.		72
73	Fully Depreciated Assets	58,420					58,420	73
74	Home Office Allocation							74
75	TOTALS	\$ 90,337	\$ 1,814	\$ 2,992	\$ 1,178		\$ 77,537	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)	\$ 509,328	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 18,486	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 20,653	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,167	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 209,446	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	N/A		93
94			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 Enfield Rehab & Hlth Care Ct

# 0053157

Report Period Beginning: 1/1/14

Ending: 12/31/14

**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

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. \_\_\_\_\_ /2015 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2016 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2017 \$ \_\_\_\_\_

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: \$ 14,804 Description: See Attached Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2006 Ford E250	578.16	\$ 6,938	17
18					18
19					19
20					20
21	TOTAL		\$ 578.16	\$ 6,938	21

\* 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.

**Enfield Rehab & Hlth Care Ct**  
**0053157**  
**Period Beginning** 1/1/2014  
**Period End** 12/31/2014

**Schedule 14A**

**XII. Rental Costs**

**B. Equipment**

**16. Description of rental amount for movable equipment**

Medical Equipment	\$ 8,497
Dishwasher	599
Laundry Equipment	59
Copier	5,233
Home Office Allocation	416
	<u>14,804</u>

Facility Name & ID Number Enfield Rehab & Hlth Care Ct # 0053157 Report Period Beginning: 1/1/14 Ending: 12/31/14  
 XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

**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.)**

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	--	---

**B. EXPENSES**

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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)	\$			

**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**

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

- (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	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	1,941	\$ 29,118	\$	1,941	\$ 29,118	1	
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		794	11,916		794	11,916	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	10A(3)	hrs		2,034	30,510		2,034	30,510	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				15,708		15,708	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	<b>TOTAL</b>			\$	4,770	\$ 71,544	\$ 15,708	4,770	\$ 87,252	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.**

Facility Name & ID Number Enfield Rehab & Hlth Care Ct

# 0053157

Report Period Beginning: 1/1/14

Ending:

12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 1,004	\$ 1,004	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>37,157</u> )	274,356	274,356	3
4	Supply Inventory (priced at <u>Cost</u> )	5,203	5,203	4
5	Short-Term Investments			5
6	Prepaid Insurance	17,928	17,928	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(21,973)	(21,973)	8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 276,518	\$ 276,518	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	25,750	15,750	13
14	Buildings, at Historical Cost	280,250	284,136	14
15	Leasehold Improvements, at Historical Cost	108,742	119,105	15
16	Equipment, at Historical Cost	84,998	90,337	16
17	Accumulated Depreciation (book methods)	(204,406)	(209,446)	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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 295,334	\$ 299,882	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 571,852	\$ 576,400	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 428,906	\$ 428,906	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	37,038	37,038	30
31	Accrued Taxes Payable (excluding real estate taxes)	18,487	18,487	31
32	Accrued Real Estate Taxes(Sch.IX-B)	6,900	6,900	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Payroll Withholdings</u>	19,442	19,442	36
37	<u>Accrued Management Fees</u>	259,394	259,394	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 770,167	\$ 770,167	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable	89,186	89,186	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 89,186	\$ 89,186	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 859,353	\$ 859,353	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (287,501)	\$ (282,953)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 571,852	\$ 576,400	48

\*(See instructions.)

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(1,693,427)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Rounding</b>	<b>(1)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(1,693,428)</b>	<b>6</b>
<b>A. Additions (deductions):</b>			
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(41,400)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(41,400)</b>	<b>17</b>
<b>B. Transfers (Itemize):</b>			
<b>18</b>	<b>Transfer of Net Assets due to Corporate Restructuring</b>	<b>1,447,327</b>	<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$ <b>1,447,327</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(287,501)</b>	<b>24</b> *

\* This must agree with page 17, line 47.

**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		
<b>A. Inpatient Care</b>				
1	Gross Revenue -- All Levels of Care	\$ 1,186,719	1	
2	Discounts and Allowances for all Levels	(76,990)	2	
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 1,109,729</b>	3	
<b>B. Ancillary Revenue</b>				
4	Day Care		4	
5	Other Care for Outpatients		5	
6	Therapy	134,750	6	
7	Oxygen	335	7	
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 135,085</b>	8	
<b>C. Other Operating Revenue</b>				
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	893	14	
15	Telephone, Television and Radio		15	
16	Rental of Facility Space		16	
17	Sale of Drugs	33,581	17	
18	Sale of Supplies to Non-Patients		18	
19	Laboratory		19	
20	Radiology and X-Ray	3,291	20	
21	Other Medical Services	1,738	21	
22	Laundry		22	
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 39,503</b>	23	
<b>D. Non-Operating Revenue</b>				
24	Contributions		24	
25	Interest and Other Investment Income***	11	25	
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 11</b>	26	
<b>E. Other Revenue (specify):****</b>				
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27	
28	<u>Miscellaneous Revenue</u>	10,961	28	
28a	<u>Transportation Revenue</u>		28a	
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 10,961</b>	29	
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 1,295,289</b>	30	

		2		
II. Expenses		Amount		
<b>A. Operating Expenses</b>				
31	General Services	290,178	31	
32	Health Care	573,104	32	
33	General Administration	273,486	33	
<b>B. Capital Expense</b>				
34	Ownership	50,808	34	
<b>C. Ancillary Expense</b>				
35	Special Cost Centers	76,027	35	
36	Provider Participation Fee	73,086	36	
<b>D. Other Expenses (specify):</b>				
37			37	
38			38	
39			39	
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 1,336,689</b>	40	
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(41,400)</b>	41	
42	<b>Income Taxes</b>		42	
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (41,400)</b>	43	

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 674,069	44
45	Private Pay - Net Inpatient Revenue	238,550	45
46	Medicare - Net Inpatient Revenue	196,763	46
47	Other-(specify) <u>Insurance Revenue</u>	1,195	47
48	Other-(specify) <u>Charity Therapy Allowance</u>	(848)	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	<b>\$ 1,109,729</b>	49

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

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

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

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

Facility Name & ID Number Enfield Rehab & Hlth Care Ct

# 0053157

Report Period Beginning:

1/1/14

Ending:

12/31/14

**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	\$ 53,083	\$ 25.52	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,977	3,050	61,292	20.10	3
4	Licensed Practical Nurses	7,008	7,309	122,613	16.78	4
5	CNAs & Orderlies	16,250	16,937	174,642	10.31	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	972	977	10,042	10.28	10
11	Social Service Workers	1,978	2,025	25,626	12.65	11
12	Dietician					12
13	Food Service Supervisor	1,800	2,016	26,491	13.14	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,553	5,929	57,579	9.71	15
16	Dishwashers					16
17	Maintenance Workers	1,829	1,903	24,776	13.02	17
18	Housekeepers	4,951	5,299	46,242	8.73	18
19	Laundry	52	52	437	8.37	19
20	Administrator	2,080	2,080	54,000	25.96	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	286	294	4,807	16.35	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>Transportation</u>	1,007	1,007	9,311	9.25	33
34	TOTAL (lines 1 - 33)	48,823	50,958	\$ 670,941 *	\$ 13.17	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$		35
36	Medical Director	Monthly 6,000	L9, C3	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 1,568	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)	\$ 7,568		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

**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	
Chastity Harris	Administrator	0	\$ 54,000	Workers' Compensation Insurance	\$ 25,883	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance	19,082	Advertising: Employee Recruitment		
				FICA Taxes	46,651	Health Care Worker Background Check		
				Employee Health Insurance	(429)	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks	497	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	270	
				Employee Relations	1,198	Miscellaneous Dues & Subscriptions	1,108	
				Home Office Allocation	7,387	Home Office Allocation	148	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 54,000	TOTAL (agree to Schedule V, line 22, col.8)		\$ 4,013		
B. Administrative - Other							Less: Public Relations Expense ( )	
Description			Amount				Non-allowable advertising ( )	
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 118,800				Yellow page advertising ( )	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 118,800	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type	Amount						
Black, Hedin, Ballard	Legal Fees	\$ 14,351					Out-of-State Travel	\$
E-Health Data Solutions	Computer Services	2,571						
Frontier	Computer Services	671					In-State Travel	
Honkamp & Krueger	Accounting Services	221		N/A				
Illinois Sec of State	Filing Fees	135					Seminar Expense	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 17,949	TOTAL		\$	Home Office Allocation	11
							Entertainment Expense ( )	
							TOTAL (agree to Sch. V, line 24, col. 8)	\$ 11

\* Attach copy of IMRF notifications

\*\*See instructions.

Enfield Rehab & Hlth Care Ct  
0053157  
Period Beginning  
Period End

1/1/2014  
12/31/2014

Schedule 21A

XIX. SUPPORT SCHEDULE  
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		17,949
<b>Home Office Allocation</b>		
Lexis Nexis	Legal	3
GoffWilson	Legal	194
Illinois Secretary of State	Legal	17
Bank of America	Legal	59
Healthcare Resources International	Legal	35
Miscellaneous	Legal	8
Addy, Bush	Legal	5
Hall, Rustom, and Fritz	Legal	6
Black, Hedin, Ballard	Legal	10
SmithAmundsen	Legal	10
CliftonLarson Allen	Accountants	413
Ginoli & Co.	Accountants	897
Miscellaneous	Computer Services	8
Odessian LLC	Computer Services	2
Optimizer	Computer Services	16
Allpayer Exchange	Computer Services	5
CCH	Computer Services	9
Prism Software	Computer Services	26
Macquarie Technology Services	Computer Services	23
Advanced Answers on Demand	Computer Services	1,223
Stratus Networks	Computer Services	161
Kemper Technology	Computer Services	477
AT&T	Computer Services	2
Ability Network	Computer Services	185
Barracuda	Computer Services	42

CIAN	Computer Services	50
Comcast	Computer Services	13
Emdeon	Computer Services	33
Charter Communications	Computer Services	2
Crawford County Title Co.	Other Prof Fees	2
Better Banks	Other Prof Fees	1
David Budde	Other Prof Fees	14
All Scripts	Other Prof Fees	9
Miscellaneous	Other Prof Fees	5
Registered Agent Solutions	Other Prof Fees	6
MGBD	Other Prof Fees	31,914
Total (agree to Schedule V, line 19, column 8)		<u>53,834</u>



Enfield Rehab & Hlth Care Ct  
0053157

Period Beginning

1/1/2014

Period End

12/31/2014

Schedule 21B

XIX. SUPPORT SCHEDULE

Legal Fees

Home Office Allocation-PHC & PHCM

Lexis Nexis	Legal	3
GoffWilson	Legal	194
Illinois Secretary of State	Legal	17
Bank of America	Legal	59
Healthcare Resources International	Legal	35
Miscellaneous	Legal	8
Addy, Bush	Legal	5
Hall, Rustom, and Fritz	Legal	6
Black, Hedin, Ballard	Legal	10
SmithAmundsen	Legal	10

Direct Facility Invoices

Black, Hedin, Ballard-Meyers Case	3/17/2014	903
Black, Hedin, Ballard-Meyers Case	6/19/2014	2,798
Illinois Secretary of State-Filing Fees	10/7/2014	100
Illinois Secretary of State-Filing Fees	10/7/2014	30
Black, Hedin, Ballard-Meyers Case	9/10/2014	7,970
Black, Hedin, Ballard-Meyers Case	12/11/2014	2,684

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

14,832

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4	N/A											
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Enfield Rehab & Hlth Care Ct# 0053157

Report Period Beginning:

1/1/14

Ending:

12/31/14**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 - \$358.01
- (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? 10 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 8,691 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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 73,086  
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 benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 893
- (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. \$ 10,322  
c. What percent of all travel expense relates to transportation of nurses and patients? N/A  
d. Have vehicle usage logs been maintained? Adquate 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? N/A  
**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. \$ 0**
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Ginoli and Company
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes  
Attach invoices and a summary of services for all architect and appraisal fees.