FOR BHF USE

LL1

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.

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

I. IDPH License ID Number: 0053132

Facility Name: Kewanee Care Home

Address: 144 Junior Avenue (Number) Kewanee (City) 61443 (Zip Code)

County: Henry

Telephone Number: (309) 853-4429 **Fax #** (309) 853-4400

HFS ID Number:

Date of Initial License for Current Owners: 06/01/76

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			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 1/1/14 to 12/31/14 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed)
(Date)
(Type or Print Name) Mark B. Petersen
(Title) Chief Executive Officer

Paid Preparer
(Signed)
(Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Kewanee Care Home # 0053132 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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	27	Skilled (SNF)	27	9,855	1
2		Skilled Pediatric (SNF/PED)			2
3	57	Intermediate (ICF)	57	20,805	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	84	TOTALS	84	30,660	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			2,678	2,678	8
9	SNF/PED					9
10	ICF	12,560	6,337	683	19,580	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,560	6,337	3,361	22,258	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.60%

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 [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 6/1/1976

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 27 and days of care provided 2,678

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

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

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

Facility Name & ID Number Kewanee Care Home # 0053132 Report Period Beginning: 1/1/14 Ending: 12/31/14

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	141,186	12,360		153,546		153,546	7,523	161,069			1
2	Food Purchase		152,669		152,669		152,669	(3,976)	148,693			2
3	Housekeeping	119,332	32,337		151,669		151,669	46	151,715			3
4	Laundry	34,272	4,383		38,655		38,655		38,655			4
5	Heat and Other Utilities			43,539	43,539		43,539	283	43,822			5
6	Maintenance	31,217	8,037	62,781	102,035		102,035	2,828	104,863			6
7	Other (specify):* Home Off. Ben. All.											7
8	TOTAL General Services	326,007	209,786	106,320	642,113		642,113	6,704	648,817			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000	27	12,027			9
10	Nursing and Medical Records	920,079	70,535	7,367	997,981		997,981	(1,601)	996,380			10
10a	Therapy			298,175	298,175		298,175		298,175			10a
11	Activities	39,594	10	150	39,754		39,754	(2,698)	39,754			11
12	Social Services	26,569			26,569		26,569		26,569			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Off. Ben. All.											15
16	TOTAL Health Care and Programs	986,242	70,545	317,692	1,374,479		1,374,479	(4,272)	1,372,905			16
	C. General Administration											
17	Administrative			127,600	127,600		127,600	(68,285)	59,315			17
18	Directors Fees											18
19	Professional Services			8,027	8,027		8,027	9,210	17,237			19
20	Dues, Fees, Subscriptions & Promotions			10,699	10,699		10,699	(563)	10,136			20
21	Clerical & General Office Expenses	33,363	6,801	13,454	53,618		53,618	83,314	136,932			21
22	Employee Benefits & Payroll Taxes			205,145	205,145		205,145	17,754	222,899			22
23	Inservice Training & Education							34	34			23
24	Travel and Seminar							30	30			24
25	Other Admin. Staff Transportation			12,533	12,533		12,533	4,568	17,101			25
26	Insurance-Prop.Liab.Malpractice			27,428	27,428		27,428	1,934	29,362			26
27	Other (specify):* Home Off. Ben. All.											27
28	TOTAL General Administration	33,363	6,801	404,886	445,050		445,050	47,996	493,046			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,345,612	287,132	828,898	2,461,642		2,461,642	50,428	2,514,768			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 & ID Number Kewanee Care Home #0053132 Report Period Beginning: 1/1/14 Ending: 12/31/14

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			44,916	44,916		44,916	21,920	66,836			30
31	Amortization of Pre-Op. & Org.							2,286	2,286			31
32	Interest			107,959	107,959		107,959	39,323	147,282			32
33	Real Estate Taxes			39,027	39,027		39,027	13,966	52,993			33
34	Rent-Facility & Grounds			95,666	95,666		95,666	(95,666)				34
35	Rent-Equipment & Vehicles			29,855	29,855		29,855	1,113	30,968			35
36	Other (specify):*											36
37	**TOTAL Ownership**			317,423	317,423		317,423	(17,058)	300,365			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		87,738		87,738		87,738		87,738			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			181,913	181,913		181,913		181,913			42
43	Other (specify):*	26,503	1,247	198,316	226,066		226,066	(226,066)				43
44	**TOTAL Special Cost Centers**	26,503	88,985	380,229	495,717		495,717	(226,066)	269,651			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,372,115	376,117	1,526,550	3,274,782		3,274,782	(192,696)	3,084,784			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 Kewanee Care Home # 0053132 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.)

	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	(4,064)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	2,393	30		9
10	Interest and Other Investment Income	(42)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(307)	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	(138,425)	43		18
19	Entertainment				19
20	Contributions		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	(48,001)	43		24
25	Fund Raising, Advertising and Promotional	(2,614)	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	(41,985)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (233,045)		$	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)	40,349	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 40,349		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (192,696)		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.		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	**TOTAL (C): (sum of lines 38-46)**			$		47

Kewanee Care Home

ID# 0053132

Report Period Beginning: 1/1/14

Ending: 12/31/14

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs-Part A	$ (5,212)	43	1
2	X-Rays-Part A	(3,392)	43	2
3	Offset of Transportation Income	(2,698)	11	3
4	Offset Chamber of Commerce Dues	(771)	20	4
5	Offset of Office Supplies Income	(174)	21	5
6	Disallowed Resident Flowers		43	6
7	Disallowed Special Events	(365)	43	7
8	Disallowed Marketing Expense	(27,750)	43	8
9	Offset Nursing Supplies Income	(1,623)	10	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(41,985)		49

Facility Name & ID Number Kewanee Care Home # 0053132 Report Period Beginning: 1/1/14 Ending: 12/31/14

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%	$ 3,277	$ 3,277	1
2	V	2	Food		Petersen Health Care, Inc.	100.00%	78	78	2
3	V	3	Housekeeping		Petersen Health Care, Inc.	100.00%	17	17	3
4	V	5	Utilities		Petersen Health Care, Inc.	100.00%	221	221	4
5	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	1,243	1,243	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%	27	27	7
8	V	10	Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	1	1	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%	2,826	2,826	12
13	V								13
14	Total			$			$ 7,690	$ * 7,690	14

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

Facility Name & ID Number Kewanee Care Home # 0053132 Report Period Beginning: 1/1/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger 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)	
15	V	20	Dues, Fees, Subs & Promotions	$	Petersen Health Care, Inc.	100.00%	$ 157	$ 157	15
16	V	21	Clerical and General Office		Petersen Health Care, Inc.	100.00%	36,886	36,886	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care, Inc.	100.00%	1,677	1,677	17
18	V	23	Inservice Training & Education		Petersen Health Care, Inc.	100.00%	19	19	18
19	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	12	12	19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	2,983	2,983	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	526	526	21
22	V	27	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		22
23	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	3,012	3,012	23
24	V	32	Interest		Petersen Health Care, Inc.	100.00%	1,916	1,916	24
25	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	148	148	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	758	758	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			$			$ 48,094	$ * 48,094	39

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

Facility Name & ID Number Kewanee Care Home # 0053132 Report Period Beginning: 1/1/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger 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)	
15	V	1	Dietary	$	Petersen Health Care Management, Inc.	100.00%	$ 4,246	$ 4,246	15
16	V	2	Food		Petersen Health Care Management, Inc.	100.00%	10	10	16
17	V	3	Housekeeping		Petersen Health Care Management, Inc.	100.00%	29	29	17
18	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	62	62	18
19	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	1,585	1,585	19
20	V	7	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		20
21	V	9	Medical Director		Petersen Health Care Management, Inc.	100.00%	0		21
22	V	10	Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	21	21	22
23	V	10A	Therapy		Petersen Health Care Management, Inc.	100.00%	0		23
24	V	15	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		24
25	V	17	Administrative	127,600	Petersen Health Care Management, Inc.	100.00%	59,315	(68,285)	25
26	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	6,384	6,384	26
27	V	20	Dues, Fees, Subs & Promotions		Petersen Health Care Management, Inc.	100.00%	51	51	27
28	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	46,602	46,602	28
29	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	16,077	16,077	29
30	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	15	15	30
31	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	18	18	31
32	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	1,585	1,585	32
33	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	133	133	33
34	V	27	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		34
35	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	204	204	35
36	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	271	271	36
37	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	114	114	37
38	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	355	355	38
39	Total			$ 127,600			$ 137,077	$ * 9,477	39

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

Facility Name & ID Number Kewanee Care Home # 0053132 Report Period Beginning: 1/1/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger 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)	
15	V	19	Professional Services	$	Kewanee Land, LLC		$	$	15
16	V	26	Insurance-Property		Kewanee Land, LLC		1,275	1,275	16
17	V	30	Depreciation		Kewanee Land, LLC		16,311	16,311	17
18	V	31	Amortization		Kewanee Land, LLC		2,286	2,286	18
19	V	32	Interest		Kewanee Land, LLC		37,178	37,178	19
20	V	33	Real Estate Taxes		Kewanee Land, LLC		13,704	13,704	20
21	V	34	Rent-Income and Grounds	95,666	Kewanee Land, LLC			(95,666)	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								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			$ 95,666			$ 70,754	$ * (24,912)	39

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

Facility Name & ID Number Kewanee Care Home # 0053132 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, L	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 Syster	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 I	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Health Care Y	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Care Y	Peoria	Mgmt/Bookkeeping	11
12			Countryview Terrace	Louisville	Petersen Health Care Y	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care Y	Peoria	Mgmt/Bookkeeping	13
14			Decatur Rehab & Health Care Center	Decatur	Petersen Health Care I	Peoria	Lessor	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Osage Beach,	Osage Beach. MO	Lessor	15
16			Eastview Terrace	Sullivan	Petersen West Frankfo	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 Ca	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 & ID Number Kewanee Care Home # 0053132 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 & ID Number Kewanee Care Home # 0053132 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 Kewanee Care Home # 0053132 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 Kewanee Care Home # 0053132 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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		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 Kewanee Care Home # 0053132 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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	1,572,338	77	$ 231,473	$ 220,289	22,258	$ 3,277	1
2	2	Food	Resident Days	1,572,338	77	5,537	0	22,258	78	2
3	3	Housekeeping	Resident Days	1,572,338	77	1,187	0	22,258	17	3
4	5	Utilities	Resident Days	1,572,338	77	15,618	0	22,258	221	4
5	6	Maintenance	Resident Days	1,572,338	77	87,839	72,289	22,258	1,243	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77	0	0	22,258	0	6
7	9	Medical Director	Resident Days	1,572,338	77	1,878	0	22,258	27	7
8	10	Nursing and Medical Records	Resident Days	1,572,338	77	71	0	22,258	1	8
9	10A	Therapy	Resident Days	1,572,338	77	0	0	22,258	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77	0	0	22,258	0	10
11	17	Administrative	Resident Days	1,572,338	77	0	0	22,258	0	11
12	19	Professional Services	Resident Days	1,572,338	77	199,631	0	22,258	2,826	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,572,338	77	11,115	0	22,258	157	13
14	21	Clerical and General Office	Resident Days	1,572,338	77	2,605,685	2,406,945	22,258	36,886	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,572,338	77	118,476	0	22,258	1,677	15
16	23	Inservice Training & Education	Resident Days	1,572,338	77	1,316	0	22,258	19	16
17	24	Travel and Seminar	Resident Days	1,572,338	77	811	0	22,258	12	17
18	25	Other Admin. Staff Transport.	Resident Days	1,572,338	77	210,720	0	22,258	2,983	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,572,338	77	37,141	0	22,258	526	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77	0	0	22,258	0	20
21	30	Depreciation	Resident Days	1,572,338	77	212,800	0	22,258	3,012	21
22	32	Interest	Resident Days	1,572,338	77	135,328	0	22,258	1,916	22
23	33	Real Estate Taxes	Resident Days	1,572,338	77	10,451	0	22,258	148	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,572,338	77	53,540	0	22,258	758	24
25	TOTALS					$ 3,940,617	$ 2,699,523		$ 55,784	25

Facility Name & ID Number Kewanee Care Home # 0053132 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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	1,572,338	77	$ 299,961	$ 294,997	22,258	$ 4,246	1
2	2	Food	Resident Days	1,572,338	77	675		22,258	10	2
3	3	Housekeeping	Resident Days	1,572,338	77	2,074	558	22,258	29	3
4	5	Utilities	Resident Days	1,572,338	77	4,349		22,258	62	4
5	6	Maintenance	Resident Days	1,572,338	77	111,954	94,000	22,258	1,585	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77			22,258		6
7	9	Medical Director	Resident Days	1,572,338	77			22,258		7
8	10	Nursing and Medical Records	Resident Days	1,572,338	77	1,457		22,258	21	8
9	10A	Therapy	Resident Days	1,572,338	77			22,258		9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77			22,258		10
11	17	Administrative	Resident Days	1,572,338	77	4,576,674	4,576,674	22,258	59,315	11
12	19	Professional Services	Resident Days	1,572,338	77	450,944		22,258	6,384	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,572,338	77	3,620		22,258	51	13
14	21	Clerical and General Office	Resident Days	1,572,338	77	3,292,039	3,146,898	22,258	46,602	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,572,338	77	1,135,672		22,258	16,077	15
16	23	Inservice Training & Education	Resident Days	1,572,338	77	1,074		22,258	15	16
17	24	Travel and Seminar	Resident Days	1,572,338	77	1,245		22,258	18	17
18	25	Other Admin. Staff Transport.	Resident Days	1,572,338	77	111,953		22,258	1,585	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,572,338	77	9,420		22,258	133	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77			22,258		20
21	30	Depreciation	Resident Days	1,572,338	77	14,419		22,258	204	21
22	32	Interest	Resident Days	1,572,338	77	19,133		22,258	271	22
23	33	Real Estate Taxes	Resident Days	1,572,338	77	8,076		22,258	114	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,572,338	77	25,085		22,258	355	24
25	TOTALS					$ 10,069,824	$ 8,113,127		$ 137,077	25

Facility Name & ID Number Kewanee Care Home # 0053132 Report Period Beginning: 1/1/14 Ending: 12/31/14

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	First Merit		X	Mortgage	Varies	1/1/14	$ 5,775,000	$ 3,854,990	12/31/39	Varies	$ 145,137	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 5,775,000	$ 3,854,990			$ 145,137	9
	B. Non-Facility Related*											
10												10
11								Interest Income Offset			(42)	11
12								Home Office Allocation-PHC			1,916	12
13								Home Office Allocation-PHCM			271	13
14	TOTAL Non-Facility Related						$	$			$ 2,145	14
15	TOTALS (line 9+line14)						$ 5,775,000	$ 3,854,990			$ 147,282	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 Kewanee Care Home # 0053132 Report Period Beginning: 1/1/14 Ending: 12/31/14

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 55,308	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	$ 53,223	2
3. Under or (over) accrual (line 2 minus line 1).		$ (2,085)	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 54,816	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **Home Office Allocation**		262	
TOTAL REFUND $ **For** **Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 52,993	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	48,577	8
	2010	51,653	9
	2011	51,663	10
	2012	53,695	11
	2013	53,223	12

Accrual based on prior year tax bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Kewanee Care Home COUNTY Henry

FACILITY IDPH LICENSE NUMBER 0053132

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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	25-05-281-017	901 W. Mill St.	$ 113.62	$ 113.62
2.	25-04-151-009	144 Junior Ave.	$ 53,022.86	$ 53,022.86
3.	25-04-152-001	821 Dewey Ave.	$ 86.12	$ 86.12
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 53,222.60	$ 53,222.60

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 Kewanee Care Home # 0053132 Report Period Beginning: 1/1/14 Ending: 12/31/14

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 12,548 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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 [X] NO
If so, please complete the following:

1. Total Amount Incurred: 228,631 2. Number of Years Over Which it is Being Amortized: 25

3. Current Period Amortization: 2,286 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	Facility	42,000	1976	$ 25,000	1
2	Facility	11,250	1992	25,621	2
3	TOTALS	53,250		$ 50,621	3

Facility Name & ID Number Kewanee Care Home # 0053132 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 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	65		1976		$ 381,128	$	30	$	$	$ 381,128	4
5	11		1998	1998	753,696		40	18,842	18,842	312,947	5
6	8		2002	2002	672,751		40	16,819	16,819	176,598	6
7											7
8											8
	Improvement Type**										
9	Various			1984	14,365		30	441	441	14,365	9
10	Various			1985	7,400		10			7,400	10
11	Various			1987	10,278		10-15			10,278	11
12	Various			1988	14,958		10-15			14,958	12
13	Various			1989	1,900		15			1,900	13
14	Various			1991	8,793		15			8,793	14
15	Various			1992	16,898		12			16,898	15
16	Various			1993	4,962		10			4,962	16
17	Various			1994	22,158		15			22,158	17
18	Various			1995	31,243		20	1,562	1,562	30,496	18
19	Tile Flooring			1996	1,083		20	54	54	1,017	19
20	Curtains Custom			1996	1,275		20	64	64	1,131	20
21	Emergency Light			1996	304		20	15	15	280	21
22	Fire Alarm			1996	2,099		20	105	105	1,960	22
23	Tile Flooring			1996	1,287		20	64	64	1,189	23
24	Boiler			1996	2,996		20	150	150	2,652	24
25	Water Heater Repair			1996	1,010		20	51	51	965	25
26	Ceiling Repairs			1996	2,117		20	106	106	2,005	26
27	Piping Repairs			1996	855		20	43	43	813	27
28	Fire Alarm			1996	1,331		20	67	67	1,217	28
29	Fire System			1996	1,564		20	78	78	1,437	29
30	Landscaping			1996	9,815		20	491	491	9,124	30
31	Landscaping			1996	1,986		20	99	99	1,815	31
32	Chrome Door Knob			1996	72		20	1	1	72	32
33	Emergency Light			1996	182		20	9	9	171	33
34	Painting			1996	672		20	34	34	640	34
35	Floor Tile			1997	8,472		20	424	424	7,561	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Kewanee Care Home # 0053132 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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Storage Shed	1997	$ 10,177	$	20	$ 509	$ 509	$ 8,865	37
38	Windows	1997	5,136		20	257	257	4,498	38
39	Ceiling Repairs	1997	8,291		20	415	415	7,193	39
40	Landscaping	1997	8,085		20	404	404	6,969	40
41	Landscaping	1997	1,298		20	65	65	1,121	41
42	Whirlpool	1997	9,343		20	467	467	7,978	42
43	Boiler	1997	3,000		20	150	150	2,575	43
44	Wing Additions	1997	3,700		20	25	25	3,000	44
45	Attic Piping	1997	3,318		20	166	166	2,891	45
46	Compressor	1997	809		20	40	40	683	46
47	Fire Alarm	1997	2,338		20	117	117	2,068	47
48	Code Alert Receiver	1997	1,863		20	93	93	1,643	48
49	New sign	1998	7,304		20			7,304	49
50	Landscaping	1998	21,500		20	1,075	1,075	17,917	50
51	Duct Work-New Wing	1999	1,494		20	75	75	1,162	51
52	Tiling	1999	914		20	46	46	713	52
53	Water Heater	1999	2,835		20	142	142	2,201	53
54	Water Heater	1999	3,766		20	188	188	2,914	54
55	Cubicle Partitions	1999	701		20	35	35	542	55
56	Beauty Salon	2000	943		20	47	47	682	56
57	Tile Flooring	2000	10,294		20	515	515	7,467	57
58	Lot/House Razed	2000	21,237		20	1,062	1,062	15,399	58
59	Concrete	2001	900		15	60	60	840	59
60	Landscaping	2001	1,045		15	70	70	981	60
61	Lighting	2001	3,438		39	88	88	1,232	61
62	Blinds/Curtains	2001	9,500		7			9,500	62
63	Landscaping	2002	24,614		15	1,641	1,641	20,512	63
64	Landscaping	2002	4,075		15	272	272	3,400	64
65	Architectural	2002	21,778		20	1,089	1,089	13,612	65
66	Carpeting	2002	2,551		20	128	128	1,600	66
67	Fire System	2002	4,677		20	234	234	2,925	67
68	Landscaping	2003	4,899		15	327	327	3,760	68
69	Simplex Time Clock	2004	3,198		10	158	158	3,198	69
70	TOTAL (lines 4 thru 69)		$ 2,186,671	$		$ 49,479	$ 49,479	$ 1,204,275	70

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

Facility Name & ID Number Kewanee Care Home # 0053132 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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,186,671	$		$ 49,479	$ 49,479	$ 1,204,275	1
2	Air Conditioner	2004	2,700		10	135	135	2,700	2
3	Side walks	2005	2,065		15	138	138	1,380	3
4	Floor covering	2005	13,891		7			13,891	4
5	Flooring	2006	28,527		25	1,141	1,141	9,699	5
6	Driveway	2007	7,101		15	473	473	3,548	6
7	Boiler	2007	2,895		10	290	290	2,175	7
8	Sprinkler System Repair	2008	2,583		5			2,583	8
9	Painting of Dining Room	2008	2,825		39	72	72	468	9
10	Sprinkler System Repair	2008	2,689		5			2,689	10
11	Fencing	2009	3,400		15	226	226	1,243	11
12	Boiler	2010	2,900		20	146	146	657	12
13	Compressor Repair	2010	2,639		7	376	376	1,222	13
14	Dry Pendent Head Replacement	2011	8,857		7	1,266	1,266	4,431	14
15	Compressor	2012	2,685		7	384	384	960	15
16	Air Conditioner-Central System	2012	2,978		15	198	198	495	16
17	Furnace, Air Conditoner, and Boiler	2012	48,229		15	1,608	1,608	4,824	17
18	A/C Repair	2013	3,455		7	494	494	741	18
19	Water Pipe Repair	2013	5,861		7	838	838	1,257	19
20	Smoke and Heat	2014	2,742		7	392	392	392	20
21	Alarm System	2014	4,344		7	621	621	621	21
22	Water Line Repair	2014	2,712		7	291	291	291	22
23	Water Pipe Repair	2014	2,550		7	273	273	273	23
24	Water Line Repair	2014	3,860		7	368	368	368	24
25	Boiler	2014	3,552		15	39	39	39	25
26									26
27									27
28	Land Improvements Booked			3,134			(3,134)		28
29	Building Booked			19,325			(19,325)		29
30	Building Improvement Booked			33,322			(33,322)		30
31									31
32	2013-Home Office Allocation-Building Improvements		10,390			249	249		32
33	2013-Home Office Allocation-Land Improvements		970			53	53		33
34	TOTAL (lines 1 thru 33)		$ 2,364,071	$ 55,781		$ 59,550	$ 3,769	$ 1,261,222	34

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

Facility Name & ID Number Kewanee Care Home # 0053132 Report Period Beginning: 1/1/14 Ending: 12/31/14

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	$ 43,713	$ 3,670	$ 4,372	$ 702	5-10 yrs.	$ 21,830	71
72	Current Year Purchases					10 yrs.		72
73	Fully Depreciated Assets	188,358					188,358	73
74	Home Office Allocation			2,914	2,914			74
75	TOTALS	$ 232,071	$ 3,670	$ 7,286	$ 3,616		$ 210,188	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	1997 Dodge Caravan	1998	$ 32,369	$	$	$		$ 32,369	76
77	Facility	2000 Town & Country	2002	35,088	1,775		(1,775)		35,088	77
78										78
79										79
80	TOTALS			$ 67,457	$ 1,775	$	$ (1,775)		$ 67,457	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)	$ 2,714,220	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 61,226	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 66,836	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 5,610	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,538,867	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 Kewanee Care Home # 0053132 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? ☐ YES ☐ NO
   If NO, see instructions.

		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: *

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	$

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: $ 13,888 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	Facility	2012 Ford E250	822.03	10,142	18
19					19
20					20
21	TOTAL		$ 1,400.19	$ 17,080	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.

Kewanee Care Home
0053132
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	$	4,840
Dishwasher		1,064
Laundry Equipment		-
Copier		6,871
Home Office Allocation		1,113
		13,888

Facility Name & ID Number Kewanee Care Home # 0053132 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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

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

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(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.

Facility Name & ID Number Kewanee Care Home # 0053132 Report Period Beginning: 1/1/14 Ending: 12/31/14

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A(3)	hrs	$	9,021	$ 135,316	$	9,021	$ 135,316	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,513	22,695		1,513	22,695	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		9,344	140,164		9,344	140,164	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				87,738		87,738	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$	19,878	$ 298,175	$ 87,738	19,878	$ 385,913	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.

STATE OF ILLINOIS

Facility Name & ID Number Kewanee Care Home # 0053132 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*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 290,134	$ 290,134	1
2	Cash-Patient Deposits	15,097	15,097	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 394,230)	492,594	492,594	3
4	Supply Inventory (priced at)	12,965	12,965	4
5	Short-Term Investments			5
6	Prepaid Insurance	29,976	30,401	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	849,754	882,581	8
9	Other(specify): Employee Advances	2,554	2,554	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,693,074	$ 1,726,326	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		50,621	13
14	Buildings, at Historical Cost		1,817,965	14
15	Leasehold Improvements, at Historical Cost	3,552	546,106	15
16	Equipment, at Historical Cost	35,088	299,528	16
17	Accumulated Depreciation (book methods)	(28,699)	(1,538,867)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs		226,345	20
21	Restricted Funds		629,259	21
22	Other Long-Term Assets (sp A/R Other			22
23	Other(specify): Security Dep & PPD Lease			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 9,941	$ 2,030,957	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,703,015	$ 3,757,283	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 968,871	$ 968,871	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	88,552	88,552	30
31	Accrued Taxes Payable (excluding real estate taxes)	127,459	127,459	31
32	Accrued Real Estate Taxes(Sch.IX-B)		54,816	32
33	Accrued Interest Payable		12,368	33
34	Deferred Compensation	5,852	5,852	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	(701)	(701)	36
37	Accrued Management Fees	135,228	135,228	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,325,261	$ 1,392,445	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,854,990	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Deferred Income	1,910,709	64,394	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,910,709	$ 3,919,384	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,235,970	$ 5,311,829	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,532,955)	$ (1,554,546)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,703,015	$ 3,757,283	48

*(See instructions.)

Facility Name & ID Number Kewanee Care Home # 0053132 Report Period Beginning: 1/1/14 Ending: 12/31/14

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 8,016,454	1
2	Restatements (describe):		2
3	Rounding		3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 8,016,454	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	648,590	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)**	$ 648,590	17
	B. Transfers (Itemize):		
18	Transfer of Net Assets to Land Company	(10,197,999)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (10,197,999)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,532,955)	24 *

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

Facility Name & ID Number Kewanee Care Home # 0053132 Report Period Beginning: 1/1/14 Ending: 12/31/14

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,654,862	1
2	Discounts and Allowances for all Levels	(481,530)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,173,332	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	575,779	6
7	Oxygen	80	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 575,859	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	4,064	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	150,066	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	10,685	20
21	Other Medical Services	4,829	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 169,644	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	42	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 42	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	1,797	28
28a	Transportation Revenue	2,698	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,495	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,923,372	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	642,113	31
32	Health Care	1,374,479	32
33	General Administration	445,050	33
	B. Capital Expense		
34	Ownership	317,423	34
	C. Ancillary Expense		
35	Special Cost Centers	313,804	35
36	Provider Participation Fee	181,913	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,274,782	40
41	**Income before Income Taxes (line 30 minus line 40)****	648,590	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 648,590	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,592,937	44
45	Private Pay - Net Inpatient Revenue	924,070	45
46	Medicare - Net Inpatient Revenue	664,461	46
47	Other-(specify) Veterans -Net Patient Revenue		47
48	Other-(specify) Charity and Insurance Contractual Allowance	(8,136)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,173,332	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 Kewanee Care Home # 0053132 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 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,080	$ 69,260	$ 33.30	1
2	Assistant Director of Nursing	693	789	15,787	20.01	2
3	Registered Nurses	4,078	4,086	88,288	21.61	3
4	Licensed Practical Nurses	14,408	15,093	264,004	17.49	4
5	CNAs & Orderlies	42,324	44,101	454,426	10.30	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,935	2,015	22,304	11.07	9
10	Activity Assistants					10
11	Social Service Workers	1,641	1,817	26,569	14.62	11
12	Dietician					12
13	Food Service Supervisor	2,064	2,064	24,865	12.05	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,981	13,370	116,321	8.70	15
16	Dishwashers					16
17	Maintenance Workers	1,995	2,162	31,217	14.44	17
18	Housekeepers	12,743	13,280	119,332	8.99	18
19	Laundry	3,357	3,631	34,272	9.44	19
20	Administrator	2,003	2,027	59,315	29.26	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,138	2,242	33,363	14.88	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) See PG20A	4,963	5,115	72,207	14.12	33
34	TOTAL (lines 1 - 33)	109,403	113,872	$ 1,431,530 *	$ 12.57	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	12,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,646	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 16,646		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

Kewanee Care Home
0053132
Period Beginning **1/1/2014**
Period End **12/31/2014**

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		1,491	1,491	28,314	18.99
Transportation		1,627	1,731	17,290	9.99
Marketing		1,845	1,893	26,603	14.05
	TOTAL	4,963	5,115	72,207	

Facility Name & ID Number Kewanee Care Home # 0053132 Report Period Beginning: 1/1/14 Ending: 12/31/14

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Michelle Young	Administrator	0	$ 20,469
Linda Verway	Administrator	0	38,946
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 59,415

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 127,600
TOTAL (agree to Schedule V, line 17, col. 3)	$ 127,600
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Honkamp Krueger & Co.	Accounting Fees	$ 531
Comcast Communications	Computer Services	1,818
E-Health Data Solutions	Computer Services	2,220
Illinois Secretary of State	Filing Fees	250
John Lams	Consulting Fees	508
Curaspan	Data Services	2,700
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 8,027

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 52,003
Unemployment Compensation Insurance	47,819
FICA Taxes	99,862
Employee Health Insurance	3,072
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	2,055
Employee Retirement	334
Home Office Allocation	17,754
TOTAL (agree to Schedule V, line 22, col.8)	$ 222,899

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

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 5,970
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 140.8)	
Patient Background Checks	1,408
Miscellaneous Licenses & Permits	750
Miscellaneous Dues & Subscriptions	2,571
Home Office Allocation	208
Less: Public Relations Expense	(771)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,136

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Home Office Allocation	30
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 30

**See instructions.

Kewanee Care Home
0053132
Period Beginning **1/1/2014**
Period End **12/31/2014**

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	**Type**	**Amount**
Total (agree to Schedule V, line 19, column 3)		8,027
Home Office Allocation-PHC, PHCM, & PHC II		
Lexis Nexis	Legal	7
GoffWilson	Legal	519
Illinois Secretary of State	Legal	47
Bank of America	Legal	157
Healthcare Resources International	Legal	94
Miscellaneous	Legal	20
Addy, Bush	Legal	13
Hall, Rustom, and Fritz	Legal	16
Black, Hedin, Ballard	Legal	27
SmithAmundsen	Legal	28
CliftonLarson Allen	Accountants	1,103
Ginoli & Co.	Accountants	1,012
Miscellaneous	Computer Services	20
Odessian LLC	Computer Services	6
Optimizer	Computer Services	44
Allpayer Exchange	Computer Services	14
CCH	Computer Services	23
Prism Software	Computer Services	70
Macquarie Technology Services	Computer Services	61
Advanced Answers on Demand	Computer Services	3269
Stratus Networks	Computer Services	431
Kemper Technology	Computer Services	1275
AT&T	Computer Services	5
Ability Network	Computer Services	494
Barracuda	Computer Services	113

CIAN	Computer Services	135
Comcast	Computer Services	34
Emdeon	Computer Services	87
Charter Communications	Computer Services	5
Crawford County Title Co.	Other Prof Fees	6
Better Banks	Other Prof Fees	4
David Budde	Other Prof Fees	38
All Scripts	Other Prof Fees	26
Miscellaneous	Other Prof Fees	7
Total (agree to Schedule V, line 19, column 8)		17,237

Facility Name & ID Number Kewanee Care Home # 0053132 Report Period Beginning: 1/1/14 Ending: 12/31/14

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	Amount of Expense Amortized Per Year								
					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	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Kewanee Care Home # 0053132 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 - 1800.00**

(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. $ **14,239** 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. $ **181,913**
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. $ **4,064**

(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. $ **2,698**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **Adqequate 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 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. **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.