

		FOR BHF USE					

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2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

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>I. IDPH License ID Number: <u>0053124</u></p> <p>Facility Name: <u>Decatur Rehab & Hlth Care Ct</u></p> <p>Address: <u>136 S Dipper Lane</u> <u>Decatur</u> <u>62522</u> <small>Number City Zip Code</small></p> <p>County: <u>Macon</u></p> <p>Telephone Number: <u>(217) 428-7767</u> Fax # <u>(217) 428-2555</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>10/1/2005</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Mike Kocher</u> Telephone Number: <u>(309)689-5850</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2015</u> to <u>12/31/2015</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" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;"> (Signed) _____ (Type or Print Name) <u>Mark B. Petersen</u> (Title) <u>Chief Executive Officer</u> </td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;"> (Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____ </td> </tr> </table> <p align="right"> 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 </p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Mark B. Petersen</u> (Title) <u>Chief Executive Officer</u>	Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Mark B. Petersen</u> (Title) <u>Chief Executive Officer</u>							
Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____							

Facility Name & ID Number Decatur Rehab & Hlth Care Ct

0053124 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	58	Intermediate (ICF)	58	21,170	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	58	TOTALS	58	21,170	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					8
9	SNF/PED					9
10	ICF	10,672	1,168	1,962	13,802	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,672	1,168	1,962	13,802	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.20%

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 _____ NO

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

YES NO If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2015 Fiscal Year: 12/31/2015

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

Facility Name & ID Number

Decatur Rehab & Hlth Care Ct

0053124

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	116,043	7,871		123,914		123,914	2,675	126,589		1
2	Food Purchase		86,606		86,606		86,606	(1,741)	84,865		2
3	Housekeeping	126,137	22,020		148,157		148,157	21	148,178		3
4	Laundry		4,412		4,412		4,412		4,412		4
5	Heat and Other Utilities			39,201	39,201		39,201	154	39,355		5
6	Maintenance	30,514	10,273	24,046	64,833		64,833	1,061	65,894		6
7	Other (specify):* Home Office Ben. Allocation										7
8	TOTAL General Services	272,694	131,182	63,247	467,123		467,123	2,170	469,293		8
	B. Health Care and Programs										
9	Medical Director			15,000	15,000		15,000		15,000		9
10	Nursing and Medical Records	656,263	53,066	3,190	712,519		712,519	(180)	712,339		10
10a	Therapy										10a
11	Activities	26,049	425	2,985	29,459		29,459	(4,533)	24,926		11
12	Social Services	3,863			3,863		3,863		3,863		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Office Ben. Allocation										15
16	TOTAL Health Care and Programs	686,175	53,491	21,175	760,841		760,841	(4,713)	756,128		16
	C. General Administration										
17	Administrative			177,100	177,100		177,100	(107,112)	69,988		17
18	Directors Fees										18
19	Professional Services			6,910	6,910		6,910	8,661	15,571		19
20	Dues, Fees, Subscriptions & Promotions			3,652	3,652		3,652	748	4,400		20
21	Clerical & General Office Expenses	31,355	1,956	19,372	52,683		52,683	29,926	82,609		21
22	Employee Benefits & Payroll Taxes			125,693	125,693		125,693	20,115	145,808		22
23	Inservice Training & Education							206	206		23
24	Travel and Seminar							47	47		24
25	Other Admin. Staff Transportation			2,518	2,518		2,518	2,105	4,623		25
26	Insurance-Prop.Liab.Malpractice			18,916	18,916		18,916	323	19,239		26
27	Other (specify):* Home Office Ben. Allocation										27
28	TOTAL General Administration	31,355	1,956	354,161	387,472		387,472	(44,981)	342,491		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	990,224	186,629	438,583	1,615,436		1,615,436	(47,524)	1,567,912		29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 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	
	D. Ownership											
30	Depreciation			20,971	20,971		20,971	6,290	27,261			30
31	Amortization of Pre-Op. & Org.							5,417	5,417			31
32	Interest			2,547	2,547		2,547	24,127	26,674			32
33	Real Estate Taxes			22,136	22,136		22,136	351	22,487			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			22,181	22,181		22,181	406	22,587			35
36	Other (specify):* Home Office Ben. Allocation											36
37	TOTAL Ownership			67,835	67,835		67,835	36,591	104,426			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		45,265		45,265		45,265		45,265			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			115,484	115,484		115,484		115,484			42
43	Other (specify):* Home Office Ben. Allocati	26,813		23,268	50,081		50,081	(50,081)				43
44	TOTAL Special Cost Centers	26,813	45,265	138,752	210,830		210,830	(50,081)	160,749			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,017,037	231,894	645,170	1,894,101		1,894,101	(61,014)	1,833,087			45

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

VI. ADJUSTMENT DETAIL

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

		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	(1,745)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,832)	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	963	30		9
10	Interest and Other Investment Income	(483)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(125)	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	(16,468)	43		18
19	Entertainment				19
20	Contributions	(200)	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				24
25	Fund Raising, Advertising and Promotional	(28,430)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(6,883)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (56,203)		\$	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)	(4,811)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (4,811)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (61,014)		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	TOTAL (C): (sum of lines 38-46)			\$		47

Decatur Rehab & Hlth Care Ct

ID# 0053124

Report Period Beginning: 1/1/2015

Ending: 12/31/2015

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Offset Transportation Revenue	\$ (4,533)	11	1
2	Disallowed Special Events	(29)	43	2
3	Offset Miscellaneous Office Supplies Revenue	(62)	21	3
4	Labs Part A	(975)	43	4
5	Resident Flower	(22)	43	5
6	X-Rays Part A	(1,000)	43	6
7	Offset Misc. Nursing Supplies Revenue	(262)	10	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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30				30
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32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		(6,883)	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%	\$ 0	\$	1	
2	V	2 Food		Petersen Health Care, Inc.	100.00%	0		2	
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	0		3	
4	V	5 Utilities		Petersen Health Care, Inc.	100.00%	0		4	
5	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	0		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%	0		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%	135	135	12	
13	V							13	
14	Total		\$			\$ 135	\$ *	135	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	20 Dues, Fees, Subs & Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 36	\$	36	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	0			16
17	V	22 Employee Benefits and Payroll Taxes		Petersen Health Care, Inc.	100.00%	0			17
18	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	0			18
19	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	0			19
20	V	25 Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	0			20
21	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	0			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%	523		523	23
24	V	32 Interest		Petersen Health Care, Inc.	100.00%	0			24
25	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	0			25
26	V	35 Rent-Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	0			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		\$			\$ 559	\$ *	559	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1 Dietary	\$	Petersen Health Wellness, LLC	100.00%	\$ 0	\$	15	
16	V	2 Food		Petersen Health Wellness, LLC	100.00%	0		16	
17	V	3 Housekeeping		Petersen Health Wellness, LLC	100.00%	0		17	
18	V	4 Laundry		Petersen Health Wellness, LLC	100.00%	0		18	
19	V	5 Utilities		Petersen Health Wellness, LLC	100.00%	0		19	
20	V	6 Maintenance		Petersen Health Wellness, LLC	100.00%	0		20	
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Wellness, LLC	100.00%	0		21	
22	V	10 Nursing and Medical Records		Petersen Health Wellness, LLC	100.00%	0		22	
23	V	15 Mgmt. Allocation of Benefits		Petersen Health Wellness, LLC	100.00%	0		23	
24	V	17 Administrative		Petersen Health Wellness, LLC	100.00%	0		24	
25	V	19 Professional Services		Petersen Health Wellness, LLC	100.00%	3,795	3,795	25	
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Wellness, LLC	100.00%	627	627	26	
27	V	21 Clerical and General Office		Petersen Health Wellness, LLC	100.00%	0		27	
28	V	22 Employee Benefits & Payroll		Petersen Health Wellness, LLC	100.00%	60	60	28	
29	V	23 Inservice Training & Education		Petersen Health Wellness, LLC	100.00%	0		29	
30	V	24 Travel and Seminar		Petersen Health Wellness, LLC	100.00%	0		30	
31	V	25 Other Admin. Staff Transport.		Petersen Health Wellness, LLC	100.00%	0		31	
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Wellness, LLC	100.00%	0		32	
33	V	30 Depreciation		Petersen Health Wellness, LLC	100.00%	0		33	
34	V	31 Amortization		Petersen Health Wellness, LLC	100.00%	5,417	5,417	34	
35	V	32 Interest		Petersen Health Wellness, LLC	100.00%	24,455	24,455	35	
36	V	33 Real Estate Taxes		Petersen Health Wellness, LLC	100.00%	0		36	
37	V	34 Rent-Facility and Grounds		Petersen Health Wellness, LLC	100.00%	0		37	
38	V	35 Rent-Equipment & Vehicles		Petersen Health Wellness, LLC	100.00%	0		38	
39	Total		\$			\$ 34,354	\$ *	34,354	39

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

Facility Name & ID Number

Decatur Rehab & Hlth Care Ct

0053124

Report Period Beginning:

1/1/2015

Ending: 12/31/2015

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%	\$ 2,675	\$ 2,675	15
16	V	2 Food		Petersen Health Care Management, Inc.	100.00%	4	4	16
17	V	3 Housekeeping		Petersen Health Care Management, Inc.	100.00%	21	21	17
18	V	5 Utilities		Petersen Health Care Management, Inc.	100.00%	154	154	18
19	V	6 Maintenance		Petersen Health Care Management, Inc.	100.00%	1,061	1,061	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%	82	82	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	177,100	Petersen Health Care Management, Inc.	100.00%	69,988	(107,112)	25
26	V	19 Professional Services		Petersen Health Care Management, Inc.	100.00%	4,731	4,731	26
27	V	20 Dues, Fees, Subs & Promotions		Petersen Health Care Management, Inc.	100.00%	85	85	27
28	V	21 Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	29,988	29,988	28
29	V	22 Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	20,055	20,055	29
30	V	23 Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	206	206	30
31	V	24 Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	47	47	31
32	V	25 Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	2,105	2,105	32
33	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	323	323	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%	4,804	4,804	35
36	V	32 Interest		Petersen Health Care Management, Inc.	100.00%	155	155	36
37	V	33 Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	351	351	37
38	V	35 Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	406	406	38
39	Total		\$ 177,100			\$ 137,241	\$ * (39,859)	39

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

Facility Name & ID Number

Decatur Rehab & Hlth Care Ct

0053124

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

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 Hospitality L	Peoria	Hospitality	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	Petersen Health Prope	Peoria	Mgmt/Bookkeeping	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

Decatur Rehab & Hlth Care Ct

0053124

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Mason Point	Sullivan				1
2			McLeansboro Rehab & Health Care Center	McLeansboro				2
3			Mt. Vernon Health Care Center	Mt. Vernon				3
4			Newman Rehab & Health Care Center	Newman				4
5			Nokomis Rehab & Health Care Center	Nokomis				5
6			North Aurora Care Center	North Aurora				6
7			Palm Terrace of Mattoon	Mattoon				7
8			Piper City Rehab & Living Center	Piper City				8
9			Pleasant View Rehab & Health Care Center	Morrison				9
10			Polo Rehabilitation & Health Care Center	Polo				10
11			Prairie City Rehab & Health Care Center	Prairie City				11
12			Robings Manor Nursing Home	Brighton				12
13			Rochelle Gardens	Rochelle				13
14			Rochelle Rehab & Health Care Center	Rochelle				14
15			Rock Falls Rehab & Health Care Center	Rock Falls				15
16			Arrow Wood Independent Living	Rock Falls				16
17			Roseville Rehab and Health Care Center	Roseville				17
18			Rosiclare Rehab & Health Care Center	Rosiclare				18
19			Royal Oaks Care Center	Kewanee				19
20			Sandwich Rehab & Health Care Center	Sandwich				20
21			Iron Wood Independent Living	Sandwich				21
22			Shawnee Rose Care Center	Harrisburg				22
23			Shelbyville Rehab & Health Care Center	Shelbyville				23
24			South Elgin Rehab & Health Care Center	South Elgin				24
25			Sullivan Health Care Center	Sullivan				25
26			Sunset Manor Nursing Home	Canton				26
27			Swansea Rehab & Health Care	Swansea				27
28			Timbercreek Rehab & Health Center	Pekin				28
29			Toulon Health Care Center	Toulon				29
30			Tuscola Health Care Center	Tuscola				30

Facility Name & ID Number

Decatur Rehab & Hlth Care Ct

0053124

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

VII. RELATED PARTIES

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

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

Facility Name & ID Number

Decatur Rehab & Hlth Care Ct

0053124

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

VII. RELATED PARTIES

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

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

Facility Name & ID Number Decatur Rehab & Hlth Care Ct # 0053124 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3	N/A										3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Decatur Rehab & Hlth Care Ct

0053124

Report Period Beginning:

1/1/2015

Ending: 2/31/2015

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	1,553,881	75	\$ 0	\$ 0	13,802	\$ 0	1
2	2	Food	Resident Days	1,553,881	75	0	0	13,802	0	2
3	3	Housekeeping	Resident Days	1,553,881	75	0	0	13,802	0	3
4	5	Utilities	Resident Days	1,553,881	75	0	0	13,802	0	4
5	6	Maintenance	Resident Days	1,553,881	75	0	0	13,802	0	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75	0	0	13,802	0	6
7	9	Medical Director	Resident Days	1,553,881	75	0	0	13,802	0	7
8	10	Nursing and Medical Records	Resident Days	1,553,881	75	0	0	13,802	0	8
9	10A	Therapy	Resident Days	1,553,881	75	0	0	13,802	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75	0	0	13,802	0	10
11	17	Administrative	Resident Days	1,553,881	75	0	0	13,802	0	11
12	19	Professional Services	Resident Days	1,553,881	75	15,159	0	13,802	135	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,553,881	75	4,077	0	13,802	36	13
14	21	Clerical and General Office	Resident Days	1,553,881	75	0	0	13,802	0	14
15	22	Employee Benefits and Payroll Tax	Resident Days	1,553,881	75	0	0	13,802	0	15
16	23	Inservice Training & Education	Resident Days	1,553,881	75	0	0	13,802	0	16
17	24	Travel and Seminar	Resident Days	1,553,881	75	0	0	13,802	0	17
18	25	Other Admin. Staff Transport.	Resident Days	1,553,881	75	0	0	13,802	0	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,553,881	75	0	0	13,802	0	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75	0	0	13,802	0	20
21	30	Depreciation	Resident Days	1,553,881	75	58,874	0	13,802	523	21
22	32	Interest	Resident Days	1,553,881	75	0	0	13,802	0	22
23	33	Real Estate Taxes	Resident Days	1,553,881	75	0	0	13,802	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,553,881	75	0	0	13,802	0	24
25	TOTALS					\$ 78,110	\$		\$ 694	25

Facility Name & ID Number Decatur Rehab & Hlth Care Ct

0053124

Report Period Beginning:

1/1/2015

Ending: 2/31/2015

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 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

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	111,418	11		13,802		1
2	2	Food	Resident Days	111,418	11		13,802		2
3	3	Housekeeping	Resident Days	111,418	11		13,802		3
4	4	Laundry	Resident Days	111,418	11		13,802		4
5	5	Utilities	Resident Days	111,418	11		13,802		5
6	6	Maintenance	Resident Days	111,418	11		13,802		6
7	7	Mgmt. Allocation of Benefits	Resident Days	111,418	11		13,802		7
8	10	Nursing and Medical Records	Resident Days	111,418	11		13,802		8
9	15	Mgmt. Allocation of Benefits	Resident Days	111,418	11		13,802		9
10	17	Administrative	Resident Days	111,418	11		13,802		10
11	19	Professional Services	Resident Days	111,418	11	30,633	13,802	3,795	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	111,418	11	5,064	13,802	627	12
13	21	Clerical and General Office	Resident Days	111,418	11		13,802		13
14	22	Employee Benefits & Payroll	Resident Days	111,418	11	484	13,802	60	14
15	23	Inservice Training & Education	Resident Days	111,418	11		13,802		15
16	24	Travel and Seminar	Resident Days	111,418	11		13,802		16
17	25	Other Admin. Staff Transport.	Resident Days	111,418	11		13,802		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	111,418	11		13,802		18
19	30	Depreciation	Resident Days	111,418	11		13,802		19
20	31	Amortization	Resident Days	111,418	11	43,728	13,802	5,417	20
21	32	Interest	Resident Days	111,418	11	197,419	13,802	24,455	21
22	33	Real Estate Taxes	Resident Days	111,418	11		13,802		22
23	34	Rent-Facility and Grounds	Resident Days	111,418	11		13,802		23
24	35	Rent-Equipment & Vehicles	Resident Days	111,418	11		13,802		24
25	TOTALS					\$ 277,328	\$	\$ 34,354	25

Facility Name & ID Number Decatur Rehab & Hlth Care Ct

0053124

Report Period Beginning:

1/1/2015

Ending: 2/31/2015

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	1,553,881	75	\$ 301,135	\$ 292,840	13,802	\$ 2,675	1
2	2	Food	Resident Days	1,553,881	75	480		13,802	4	2
3	3	Housekeeping	Resident Days	1,553,881	75	2,362	2,362	13,802	21	3
4	5	Utilities	Resident Days	1,553,881	75	17,327		13,802	154	4
5	6	Maintenance	Resident Days	1,553,881	75	119,427	88,000	13,802	1,061	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75			13,802		6
7	9	Medical Director	Resident Days	1,553,881	75			13,802		7
8	10	Nursing and Medical Records	Resident Days	1,553,881	75	9,192		13,802	82	8
9	10A	Therapy	Resident Days	1,553,881	75			13,802		9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75			13,802		10
11	17	Administrative	Resident Days	1,553,881	75	4,799,018	4,755,666	13,802	69,988	11
12	19	Professional Services	Resident Days	1,553,881	75	532,666		13,802	4,731	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,553,881	75	9,548		13,802	85	13
14	21	Clerical and General Office	Resident Days	1,553,881	75	3,376,139	3,043,176	13,802	29,988	14
15	22	Employee Benefits and Payroll Tax	Resident Days	1,553,881	75	2,257,824		13,802	20,055	15
16	23	Inservice Training & Education	Resident Days	1,553,881	75	23,223		13,802	206	16
17	24	Travel and Seminar	Resident Days	1,553,881	75	5,279		13,802	47	17
18	25	Other Admin. Staff Transport.	Resident Days	1,553,881	75	236,965		13,802	2,105	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,553,881	75	36,398		13,802	323	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75			13,802		20
21	30	Depreciation	Resident Days	1,553,881	75	540,826		13,802	4,804	21
22	32	Interest	Resident Days	1,553,881	75	17,439		13,802	155	22
23	33	Real Estate Taxes	Resident Days	1,553,881	75	39,471		13,802	351	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,553,881	75	45,727		13,802	406	24
25	TOTALS					\$ 12,370,446	\$ 8,182,044		\$ 137,241	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					
		Related**					Monthly Payment Required	Date of Note				Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO									Original	Balance			
A. Directly Facility Related																
Long-Term																
1	The Private Bank		X	Mortgage	Varies	10/1/14	\$ 145,031	\$ Retired			\$ 2,547	1				
2												2				
3												3				
4												4				
5												5				
Working Capital																
6												6				
7												7				
8												8				
9	TOTAL Facility Related						\$ 145,031	\$			\$ 2,547	9				
B. Non-Facility Related*																
10												10				
11											(483)	11				
12											24,455	12				
13											155	13				
14	TOTAL Non-Facility Related						\$	\$			\$ 24,127	14				
15	TOTALS (line 9+line14)						\$ 145,031	\$			\$ 26,674	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.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.													
1. Real Estate Tax accrual used on 2014 report.		\$	23,628		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.)		\$	22,544		2										
3. Under or (over) accrual (line 2 minus line 1).		\$	(1,084)		3										
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	23,220		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. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	351	Home Office Allocation	6										
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	22,487		7										
Real Estate Tax History:															
Real Estate Tax Bill for Calendar Year:	2010	<u>23,810</u>	8	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2014 \$</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> </tr> </table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2014 \$	14	PLUS APPEAL COST FROM LINE 5 \$	15	LESS REFUND FROM LINE 6 \$	16	AMOUNT TO USE FOR RATE CALCULATION \$
FOR BHF USE ONLY															
13	FROM R. E. TAX STATEMENT FOR 2014 \$														
14	PLUS APPEAL COST FROM LINE 5 \$														
15	LESS REFUND FROM LINE 6 \$														
16	AMOUNT TO USE FOR RATE CALCULATION \$														
	2011	<u>23,400</u>	9												
	2012	<u>23,436</u>	10												
	2013	<u>22,939</u>	11												
	2014	<u>22,544</u>	12												
Accrual based on prior year tax bill.															

NOTES:

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

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 8,653 B. General Construction Type: Exterior Brick Frame Concrete Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: 95,556 2. Number of Years Over Which it is Being Amortized: 20
 3. Current Period Amortization: 5,417 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>43,560</u>	<u>2005</u>	<u>\$ 37,500</u>	1
2					2
3	TOTALS	43,560		\$ 37,500	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	58	2005	1970	\$ 275,500	\$	25	\$ 11,020	\$ 11,020	\$ 115,710	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Original Land Improvements	2005		10,000		15	667	667	7,003	9
10	Sidewalks	2006		2,311		15	154	154	1,463	10
11	Remodel Nurses Station	2007		6,718		15	448	448	3,808	11
12	Water Heater-100 Gallon	2008		5,604		5			5,604	12
13	Painting-Exterior	2009		4,908		15	328	328	2,368	13
14	Sprinkler System Installation	2009		11,774		15	785	785	5,102	14
15	Windows Installation-(41)	2009		11,234		15	749	749	4,868	15
16	Dry Pendant Installation	2010		6,270		15	418	418	2,299	16
17	Sidewalk Replacement	2011		2,850		15	190	190	855	17
18	Roofing-Flat Section of Building	2013		10,400		15	694	694	1,735	18
19	Parking Lot-Asphalt	2013		23,468		25	938	938	2,345	19
20	Air Handler	2015		2,905		15	97	97	97	20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29	Land Improvements Booked				1,011			(1,011)		29
30	Building Booked				11,069			(11,069)		30
31	Building Improvement Booked				4,438			(4,438)		31
32										32
33	2015-Home Office Allocation-Building Improvements			6,039			145	145		33
34	2015-Home Office Allocation-Land Improvements			564			36	36		34
35										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

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								63				
64								64				
65								65				
66								66				
67								67				
68								68				
69								69				
70	TOTAL (lines 4 thru 69)	\$	380,545	\$	16,518	\$	16,669	\$	151	\$	153,257	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	\$ 57,848	\$ 4,140	\$ 5,314	\$ 1,174	5-10 yrs.	\$ 33,472	71
72	Current Year Purchases	2,625	313	132	(181)	10 yrs.	132	72
73	Fully Depreciated Assets	62,280					62,280	73
74	Home Office Allocation			5,146	5,146			74
75	TOTALS	\$ 122,753	\$ 4,453	\$ 10,592	\$ 6,139		\$ 95,884	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)	\$ 540,798	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 20,971	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 27,261	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 6,290	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 249,141	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	Vacant Land	\$ 75,000	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 75,000	\$	\$	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 Decatur Rehab & Hlth Care Ct

0053124

Report Period Beginning: 1/1/2015

Ending: 12/31/2015

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.	_____ /2016	\$ _____
-----	-------------	----------

13.	_____ /2017	\$ _____
-----	-------------	----------

14.	_____ /2018	\$ _____
-----	-------------	----------

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

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

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 12,646 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	2012 Ford E250	\$ 828.41	\$ 9,941	17
18					18
19					19
20					20
21	TOTAL		\$ 828.41	\$ 9,941	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.

Decatur Rehab & Hlth Care Ct
0053124

Period Beginning **1/1/2015**
Period End **12/31/2015**

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$	4,308
Dishwasher		655
Copier		7,277
Home Office Allocation		406
		<u>12,646</u>

Facility Name & ID Number Decatur Rehab & Hlth Care Ct # 0053124 Report Period Beginning: 1/1/2015 Ending: 12/31/2015
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?</p> <p><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

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							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				45,265		45,265	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			\$		\$	45,265		\$ 45,265	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 Decatur Rehab & Hlth Care Ct# 0053124Report Period Beginning: 1/1/2015

Ending:

12/31/2015

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2015

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (379,411)	\$ (379,411)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>77,002</u>)	756,742	756,742	3
4	Supply Inventory (priced at <u>Cost</u>)	7,380	7,380	4
5	Short-Term Investments			5
6	Prepaid Insurance	18,940	18,940	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Security Deposit & PPD Lease</u>	2,858	2,858	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 406,509	\$ 406,509	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	127,661	37,500	13
14	Buildings, at Historical Cost	275,500	281,539	14
15	Leasehold Improvements, at Historical Cost	83,281	99,006	15
16	Equipment, at Historical Cost	118,043	122,753	16
17	Accumulated Depreciation (book methods)	(250,546)	(249,141)	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): <u>Vacant Land</u>		75,000	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 353,939	\$ 366,657	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 760,448	\$ 773,166	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 298,745	\$ 298,745	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	53,496	53,496	30
31	Accrued Taxes Payable (excluding real estate taxes)	54,335	54,335	31
32	Accrued Real Estate Taxes(Sch.IX-B)	23,220	23,220	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	11,661	11,661	36
37	<u>Accrued Management Fees</u>	322,716	322,716	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 764,173	\$ 764,173	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Intercompany Loans</u>	59	59	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 59	\$ 59	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 764,232	\$ 764,232	46
47	TOTAL EQUITY(page 18, line 24)	\$ (3,784)	\$ 8,934	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 760,448	\$ 773,166	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 30,041	1
2	Restatements (describe):		2
3	Prior Period Adjustment Made After Cost Reports Were Filed	1,997	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 32,038	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(35,822)	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)	\$ (35,822)	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (3,784)	24 *

* 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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 1,826,913	1
2	Discounts and Allowances for all Levels	(65,119)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,761,794	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	42,775	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 42,775	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,745	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	42,956	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	3,502	20
21	Other Medical Services	167	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 48,370	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	483	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 483	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Transportation Revenue	4,533	28
28a	Miscellaneous Revenue	324	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,857	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,858,279	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	467,123	31
32	Health Care	760,841	32
33	General Administration	387,472	33
B. Capital Expense			
34	Ownership	67,835	34
C. Ancillary Expense			
35	Special Cost Centers	95,346	35
36	Provider Participation Fee	115,484	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,894,101	40
41	Income before Income Taxes (line 30 minus line 40)**	(35,822)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (35,822)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,389,264	44
45	Private Pay - Net Inpatient Revenue	166,464	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) <u>Veterans -Net Patient Revenue</u>	206,066	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 1,761,794	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 Decatur Rehab & Hlth Care Ct

0053124

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

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	2,138	2,138	\$ 70,794	\$ 33.11	1
2	Assistant Director of Nursing	347	347	8,320	23.98	2
3	Registered Nurses	4,383	4,513	115,347	25.56	3
4	Licensed Practical Nurses	7,686	7,866	170,908	21.73	4
5	CNAs & Orderlies	24,128	24,589	257,178	10.46	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,953	2,006	25,994	12.96	9
10	Activity Assistants					10
11	Social Service Workers	260	260	3,863	14.86	11
12	Dietician					12
13	Food Service Supervisor	1,890	1,970	28,632	14.53	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,970	9,357	87,411	9.34	15
16	Dishwashers					16
17	Maintenance Workers	1,959	1,997	30,514	15.28	17
18	Housekeepers	12,187	12,650	126,137	9.97	18
19	Laundry					19
20	Administrator	2,112	2,200	69,988	31.81	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,992	2,040	31,355	15.37	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,265	1,265	33,716	26.65	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>See PG20A</u>	1,826	1,826	26,868	14.71	33
34	TOTAL (lines 1 - 33)	73,096	75,024	\$ 1,087,025 *	\$ 14.49	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 15,000	L9,C3	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 3,010	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)	\$ 18,010		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

Decatur Rehab & Hlth Care Ct
 0053124
 Period Beginning 1/1/2015
 Period End 12/31/2015

Schedule 20A

XVIII. Staffing and Salary Costs

			Reporting Period	
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries, Wages	Average Hourly Wage
Transportation	6	6	55	9.17
Marketing	1,820	1,820	26,813	14.73
TOTAL	<u>1,826</u>	<u>1,826</u>	<u>26,868</u>	

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	
Joe Harding	Administrator	0	\$ 41,917	Workers' Compensation Insurance	\$ 35,523	IDPH License Fee	\$ 2,453	
Christopher White	Administrator	0	28,071	Unemployment Compensation Insurance	30,649	Advertising: Employee Recruitment		
				FICA Taxes	72,072	Health Care Worker Background Check		
				Employee Health Insurance	(15,310)	(Indicate # of checks performed <u>69</u>)	571	
				Employee Meals		Miscellaneous Licenses & Permits	628	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Dues & Subscriptions		
				Employee Relations	2,759	Home Office Allocation	748	
				Home Office Allocation	20,115			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 69,988	TOTAL (agree to Schedule V, line 22, col.8)		\$ 4,400		
B. Administrative - Other							Less: Public Relations Expense ()	
Description			Amount				Non-allowable advertising ()	
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 177,100				Yellow page advertising ()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 177,100				TOTAL (agree to Sch. V, line 20, col. 8)	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Comcast Cable	Computer Services		\$ 1,131				Out-of-State Travel	\$
E-Health Data Solutions	Computer Services		4,182					
Honkamp Krueger	Accounting Services		384				In-State Travel	
Allscript	Computer Services		1,213	N/A				
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 6,910	TOTAL		\$	Seminar Expense	
							Home Office Allocation	47
							Entertainment Expense ()	
							TOTAL (agree to Sch. V, line 24, col. 8)	\$ 47

* Attach copy of IMRF notifications

**See instructions.

Decatur Rehab & Hlth Care Ct
0053124

Period Beginning

1/1/2015

Period End

12/31/2015

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		6,910
Home Office Allocation		
Denton's US LLP	Legal	67
Applegate and Thorne	Legal	10
Miller Hall and Triggs	Legal	10
Healthcare Resources International	Legal	55
Lexis Nexis	Legal	4
GoffWilson	Legal	460
Private Bank	Legal	1355
CliftonLarson Allen	Accountants	718
Ginoli & Co.	Accountants	2,271
Private Bank	Accountants	600
Miscellaneous	Computer Services	35
CCH	Computer Services	8
PTC Select	Computer Services	11
Advanced Answers on Demand	Computer Services	1473
Stratus Networks	Computer Services	268
Kemper Technology	Computer Services	394
AT&T	Computer Services	3
Ability Network	Computer Services	379
CIAN	Computer Services	267
Comcast	Computer Services	10
Emdeon	Computer Services	22
Charter Communications	Computer Services	18
Allscripts	Computer Services	13
Allpayer Exchange	Computer Services	9
E-Health Technologies	Computer Services	6

Macquarie Technology Services	Computer Services	9
Optimizer	Other Prof Fees	26
D.J. Howard Appraisers	Other Prof Fees	23
Key Corporate Services	Other Prof Fees	78
Consolidated Land Surveying	Other Prof Fees	49
Alan Litwiller	Other Prof Fees	10

Total (agree to Schedule V, line 19, column 8)	<u>15,571</u>
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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												
5												
6	N/A											
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Decatur Rehab & Hlth Care Ct

0053124

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

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? No
If YES, give association name and amount. N/A
- (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. \$ 17,597 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
-
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 115,484
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. \$ 1,745
- (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. \$ 4,533
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? 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. N/A
Attach invoices and a summary of services for all architect and appraisal fees.