

		FOR BHF USE				

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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.

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

<p>I. IDPH License ID Number: <u>0050914</u></p> <p>Facility Name: <u>El Paso Health Care Center</u></p> <p>Address: <u>850 East Second St</u> <u>El Paso</u> <u>61738</u> Number City Zip Code</p> <p>County: <u>Woodford</u></p> <p>Telephone Number: <u>(309) 527-2700</u> Fax # <u>(309) 527-2725</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>10/20/2004</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>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 checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>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"> <tr> <td rowspan="2" style="width: 20%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Mark B. Petersen</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>Chief Executive Officer</u></td> <td></td> </tr> <tr> <td rowspan="5">Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> <td></td> </tr> <tr> <td>(Firm Name & Address) _____</td> <td></td> </tr> <tr> <td>(Telephone) () _____</td> <td>Fax # () _____</td> </tr> <tr> <td colspan="2">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</td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) <u>Mark B. Petersen</u>			(Title) <u>Chief Executive Officer</u>		Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) () _____	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	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																										
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Facility Name & ID Number El Paso Health Care Center

0050914 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	<u>123</u>	Skilled (SNF)	<u>123</u>	<u>44,895</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>123</u>	TOTALS	<u>123</u>	<u>44,895</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>39,050</u>	<u>1,177</u>	<u>916</u>	<u>41,143</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>39,050</u>	<u>1,177</u>	<u>916</u>	<u>41,143</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.64%

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 10/20/2004

J. Was the facility purchased or leased after January 1, 1978?
YES Date 10/20/2004 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 123 and days of care provided 610

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number

El Paso Health Care Center

0050914

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	186,005	23,861		209,866		209,866	7,974	217,840		1
2	Food Purchase		276,792		276,792		276,792	(490)	276,302		2
3	Housekeeping	119,790	32,809		152,599		152,599	63	152,662		3
4	Laundry	59,064	9,156		68,220		68,220		68,220		4
5	Heat and Other Utilities			158,088	158,088		158,088	459	158,547		5
6	Maintenance	48,571	13,256	32,645	94,472		94,472	3,162	97,634		6
7	Other (specify):* Home Office Ben. Allocation										7
8	TOTAL General Services	413,430	355,874	190,733	960,037		960,037	11,168	971,205		8
	B. Health Care and Programs										
9	Medical Director			24,250	24,250		24,250		24,250		9
10	Nursing and Medical Records	1,364,603	71,472	17,823	1,453,898		1,453,898	(4,654)	1,449,244		10
10a	Therapy			100,344	100,344		100,344		100,344		10a
11	Activities	120,891	3	19	120,913		120,913	(12,121)	108,792		11
12	Social Services	106,797			106,797		106,797		106,797		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Office Ben. Allocation										15
16	TOTAL Health Care and Programs	1,592,291	71,475	142,436	1,806,202		1,806,202	(16,775)	1,789,427		16
	C. General Administration										
17	Administrative			315,600	315,600		315,600	(249,767)	65,833		17
18	Directors Fees										18
19	Professional Services			8,942	8,942		8,942	89,666	98,608		19
20	Dues, Fees, Subscriptions & Promotions			13,517	13,517		13,517	3,499	17,016		20
21	Clerical & General Office Expenses	60,135	3,318	20,739	84,192		84,192	89,191	173,383		21
22	Employee Benefits & Payroll Taxes			263,765	263,765		263,765	61,490	325,255		22
23	Inservice Training & Education							615	615		23
24	Travel and Seminar							140	140		24
25	Other Admin. Staff Transportation			12,174	12,174		12,174	6,275	18,449		25
26	Insurance-Prop.Liab.Malpractice			40,286	40,286		40,286	964	41,250		26
27	Other (specify):* Home Office Ben. Allocation										27
28	TOTAL General Administration	60,135	3,318	675,023	738,476		738,476	2,073	740,549		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,065,856	430,667	1,008,192	3,504,715		3,504,715	(3,534)	3,501,181		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			48,463	48,463		48,463	8,140	56,603			30
31	Amortization of Pre-Op. & Org.							30,470	30,470			31
32	Interest			156,298	156,298		156,298	12,608	168,906			32
33	Real Estate Taxes			63,835	63,835		63,835	1,045	64,880			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			22,754	22,754		22,754	1,211	23,965			35
36	Other (specify):* Home Office Ben. Allocation											36
37	TOTAL Ownership			291,350	291,350		291,350	53,474	344,824			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		31,471		31,471		31,471		31,471			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			313,228	313,228		313,228		313,228			42
43	Other (specify):* Home Office Ben. Allocati	35,406	88	35,853	71,347		71,347	(71,347)				43
44	TOTAL Special Cost Centers	35,406	31,559	349,081	416,046		416,046	(71,347)	344,699			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,101,262	462,226	1,648,623	4,212,111		4,212,111	(21,407)	4,190,704			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 El Paso Health Care Center

0050914

Report Period Beginning: 1/1/2015

Ending: 12/31/2015

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	(503)	2		4
5	Telephone, TV & Radio in Resident Rooms	(882)	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	(8,768)	30		9
10	Interest and Other Investment Income	(12,226)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(42)	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	(30,802)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(36,818)	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	(20,026)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (110,067)		\$	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)	88,660	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 88,660		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (21,407)		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

El Paso Health Care Center

ID# 0050914

Report Period Beginning: 1/1/2015

Ending: 12/31/2015

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Labs-Part A	\$ (1,707)	43	1
2	X-Rays-Part A	(1,097)	43	2
3	Offset Miscellaneous Office Supplies Revenue	(205)	21	3
4	Offset Transportation Revenue	(12,121)	11	4
5	Disallowed Special Events	1	43	5
6	Offset Miscellaneous Nursing Supplies Revenue	(4,897)	10	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
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42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		(20,026)	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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	1 Dietary	\$	Petersen Health Care, 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%	401	401	12
13	V							13
14	Total		\$			\$ 401	\$ *	401

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	20 <u>Dues, Fees, Subs & Promotions</u>	\$	<u>Petersen Health Care, Inc.</u>	100.00%	\$ 108	\$	108	15
16	V	21 <u>Clerical and General Office</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			16
17	V	22 <u>Employee Benefits and Payroll Taxes</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			17
18	V	23 <u>Inservice Training & Education</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			18
19	V	24 <u>Travel and Seminar</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			19
20	V	25 <u>Other Admin. Staff Transport.</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			20
21	V	26 <u>Insurance-Prop./Liab./Malprac.</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			21
22	V	27 <u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			22
23	V	30 <u>Depreciation</u>		<u>Petersen Health Care, Inc.</u>	100.00%	1,559		1,559	23
24	V	32 <u>Interest</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			24
25	V	33 <u>Real Estate Taxes</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			25
26	V	35 <u>Rent-Equipment & Vehicles</u>		<u>Petersen Health Care, Inc.</u>	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		\$			\$ 1,667	\$ *	1,667	39

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

Facility Name & ID Number El Paso Health Care Center# 0050914Report Period Beginning: 1/1/2015Ending: 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 Network, LLC	100.00%	\$ 0	\$	15	
16	V	2 Food		Petersen Health Network, LLC	100.00%	0		16	
17	V	3 Housekeeping		Petersen Health Network, LLC	100.00%	0		17	
18	V	4 Laundry		Petersen Health Network, LLC	100.00%	0		18	
19	V	5 Utilities		Petersen Health Network, LLC	100.00%	0		19	
20	V	6 Maintenance		Petersen Health Network, LLC	100.00%	0		20	
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Network, LLC	100.00%	0		21	
22	V	10 Nursing and Medical Records		Petersen Health Network, LLC	100.00%	0		22	
23	V	15 Mgmt. Allocation of Benefits		Petersen Health Network, LLC	100.00%	0		23	
24	V	17 Administrative		Petersen Health Network, LLC	100.00%	0		24	
25	V	19 Professional Services		Petersen Health Network, LLC	100.00%	75,161	75,161	25	
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Network, LLC	100.00%	3,138	3,138	26	
27	V	21 Clerical and General Office		Petersen Health Network, LLC	100.00%	0		27	
28	V	22 Employee Benefits & Payroll		Petersen Health Network, LLC	100.00%	1,705	1,705	28	
29	V	23 Inservice Training & Education		Petersen Health Network, LLC	100.00%	0		29	
30	V	24 Travel and Seminar		Petersen Health Network, LLC	100.00%	0		30	
31	V	25 Other Admin. Staff Transport.		Petersen Health Network, LLC	100.00%	0		31	
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Network, LLC	100.00%	0		32	
33	V	30 Depreciation		Petersen Health Network, LLC	100.00%	1,029	1,029	33	
34	V	31 Amortization		Petersen Health Network, LLC	100.00%	30,470	30,470	34	
35	V	32 Interest		Petersen Health Network, LLC	100.00%	24,372	24,372	35	
36	V	33 Real Estate Taxes		Petersen Health Network, LLC	100.00%	0		36	
37	V	34 Rent-Facility and Grounds		Petersen Health Network, LLC	100.00%	0		37	
38	V	35 Rent-Equipment & Vehicles		Petersen Health Network, LLC	100.00%	0		38	
39	Total		\$			\$ 135,875	\$ *	135,875	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 Dietary	\$	Petersen Health Care Management, Inc.	100.00%	\$ 7,974	\$ 7,974
16	V	2 Food		Petersen Health Care Management, Inc.	100.00%	13	13
17	V	3 Housekeeping		Petersen Health Care Management, Inc.	100.00%	63	63
18	V	5 Utilities		Petersen Health Care Management, Inc.	100.00%	459	459
19	V	6 Maintenance		Petersen Health Care Management, Inc.	100.00%	3,162	3,162
20	V	7 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0	
21	V	9 Medical Director		Petersen Health Care Management, Inc.	100.00%	0	
22	V	10 Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	243	243
23	V	10A Therapy		Petersen Health Care Management, Inc.	100.00%	0	
24	V	15 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0	
25	V	17 Administrative	315,600	Petersen Health Care Management, Inc.	100.00%	65,833	(249,767)
26	V	19 Professional Services		Petersen Health Care Management, Inc.	100.00%	14,104	14,104
27	V	20 Dues, Fees, Subs & Promotions		Petersen Health Care Management, Inc.	100.00%	253	253
28	V	21 Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	89,396	89,396
29	V	22 Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	59,785	59,785
30	V	23 Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	615	615
31	V	24 Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	140	140
32	V	25 Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	6,275	6,275
33	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	964	964
34	V	27 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0	
35	V	30 Depreciation		Petersen Health Care Management, Inc.	100.00%	14,320	14,320
36	V	32 Interest		Petersen Health Care Management, Inc.	100.00%	462	462
37	V	33 Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	1,045	1,045
38	V	35 Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	1,211	1,211
39	Total		\$ 315,600			\$ 266,317	\$ * (49,283)

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

Facility Name & ID Number

El Paso Health Care Center

0050914

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

El Paso Health Care Center

0050914

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

El Paso Health Care Center

0050914

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

El Paso Health Care Center

0050914

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 El Paso Health Care Center # 0050914 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 El Paso Health Care Center

0050914

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	41,145	\$ 0	1
2	2	Food	Resident Days	1,553,881	75	0	0	41,145	0	2
3	3	Housekeeping	Resident Days	1,553,881	75	0	0	41,145	0	3
4	5	Utilities	Resident Days	1,553,881	75	0	0	41,145	0	4
5	6	Maintenance	Resident Days	1,553,881	75	0	0	41,145	0	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75	0	0	41,145	0	6
7	9	Medical Director	Resident Days	1,553,881	75	0	0	41,145	0	7
8	10	Nursing and Medical Records	Resident Days	1,553,881	75	0	0	41,145	0	8
9	10A	Therapy	Resident Days	1,553,881	75	0	0	41,145	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75	0	0	41,145	0	10
11	17	Administrative	Resident Days	1,553,881	75	0	0	41,145	0	11
12	19	Professional Services	Resident Days	1,553,881	75	15,159	0	41,145	401	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,553,881	75	4,077	0	41,145	108	13
14	21	Clerical and General Office	Resident Days	1,553,881	75	0	0	41,145	0	14
15	22	Employee Benefits and Payroll Tax	Resident Days	1,553,881	75	0	0	41,145	0	15
16	23	Inservice Training & Education	Resident Days	1,553,881	75	0	0	41,145	0	16
17	24	Travel and Seminar	Resident Days	1,553,881	75	0	0	41,145	0	17
18	25	Other Admin. Staff Transport.	Resident Days	1,553,881	75	0	0	41,145	0	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,553,881	75	0	0	41,145	0	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75	0	0	41,145	0	20
21	30	Depreciation	Resident Days	1,553,881	75	58,874	0	41,145	1,559	21
22	32	Interest	Resident Days	1,553,881	75	0	0	41,145	0	22
23	33	Real Estate Taxes	Resident Days	1,553,881	75	0	0	41,145	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,553,881	75	0	0	41,145	0	24
25	TOTALS					\$ 78,110	\$		\$ 2,068	25

Facility Name & ID Number El Paso Health Care Center

0050914

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 Network, 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	259,904	13		41,145		1
2	2	Food	Resident Days	259,904	13		41,145		2
3	3	Housekeeping	Resident Days	259,904	13		41,145		3
4	4	Laundry	Resident Days	259,904	13		41,145		4
5	5	Utilities	Resident Days	259,904	13		41,145		5
6	6	Maintenance	Resident Days	259,904	13		41,145		6
7	7	Mgmt. Allocation of Benefits	Resident Days	259,904	13		41,145		7
8	10	Nursing and Medical Records	Resident Days	259,904	13		41,145		8
9	15	Mgmt. Allocation of Benefits	Resident Days	259,904	13		41,145		9
10	17	Administrative	Resident Days	259,904	13		41,145		10
11	19	Professional Services	Resident Days	259,904	13	474,776	41,145	75,161	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	259,904	13	19,824	41,145	3,138	12
13	21	Clerical and General Office	Resident Days	259,904	13		41,145		13
14	22	Employee Benefits & Payroll	Resident Days	259,904	13	10,774	41,145	1,705	14
15	23	Inservice Training & Education	Resident Days	259,904	13		41,145		15
16	24	Travel and Seminar	Resident Days	259,904	13		41,145		16
17	25	Other Admin. Staff Transport.	Resident Days	259,904	13		41,145		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	259,904	13		41,145		18
19	30	Depreciation	Resident Days	259,904	13	6,500	41,145	1,029	19
20	31	Amortization	Resident Days	259,904	13	192,475	41,145	30,470	20
21	32	Interest	Resident Days	259,904	13	153,955	41,145	24,372	21
22	33	Real Estate Taxes	Resident Days	259,904	13		41,145		22
23	34	Rent-Facility and Grounds	Resident Days	259,904	13		41,145		23
24	35	Rent-Equipment & Vehicles	Resident Days	259,904	13		41,145		24
25	TOTALS					\$ 858,304	\$	\$ 135,875	25

Facility Name & ID Number El Paso Health Care Center

0050914

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	41,145	\$ 7,974	1
2	2	Food	Resident Days	1,553,881	75	480		41,145	13	2
3	3	Housekeeping	Resident Days	1,553,881	75	2,362	2,362	41,145	63	3
4	5	Utilities	Resident Days	1,553,881	75	17,327		41,145	459	4
5	6	Maintenance	Resident Days	1,553,881	75	119,427	88,000	41,145	3,162	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75			41,145		6
7	9	Medical Director	Resident Days	1,553,881	75			41,145		7
8	10	Nursing and Medical Records	Resident Days	1,553,881	75	9,192		41,145	243	8
9	10A	Therapy	Resident Days	1,553,881	75			41,145		9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75			41,145		10
11	17	Administrative	Resident Days	1,553,881	75	4,799,018	4,755,666	41,145	65,833	11
12	19	Professional Services	Resident Days	1,553,881	75	532,666		41,145	14,104	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,553,881	75	9,548		41,145	253	13
14	21	Clerical and General Office	Resident Days	1,553,881	75	3,376,139	3,043,176	41,145	89,396	14
15	22	Employee Benefits and Payroll Tax	Resident Days	1,553,881	75	2,257,824		41,145	59,785	15
16	23	Inservice Training & Education	Resident Days	1,553,881	75	23,223		41,145	615	16
17	24	Travel and Seminar	Resident Days	1,553,881	75	5,279		41,145	140	17
18	25	Other Admin. Staff Transport.	Resident Days	1,553,881	75	236,965		41,145	6,275	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,553,881	75	36,398		41,145	964	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75			41,145		20
21	30	Depreciation	Resident Days	1,553,881	75	540,826		41,145	14,320	21
22	32	Interest	Resident Days	1,553,881	75	17,439		41,145	462	22
23	33	Real Estate Taxes	Resident Days	1,553,881	75	39,471		41,145	1,045	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,553,881	75	45,727		41,145	1,211	24
25	TOTALS					\$ 12,370,446	\$ 8,182,044		\$ 266,317	25

Facility Name & ID Number El Paso Health Care Center

0050914

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

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**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
	A. Directly Facility Related																
	Long-Term																
1	Wells Fargo		X	Mortgage	Varies	1/1/15	\$ 4,130,145	\$ 3,223,740	12/31/2014	Varies	\$ 156,298	1					
2												2					
3												3					
4												4					
5												5					
	Working Capital																
6												6					
7												7					
8												8					
9	TOTAL Facility Related						\$ 4,130,145	\$ 3,223,740			\$ 156,298	9					
	B. Non-Facility Related*																
10												10					
11											(12,226)	11					
12											24,372	12					
13											462	13					
14	TOTAL Non-Facility Related						\$	\$			\$ 12,608	14					
15	TOTALS (line 9+line14)						\$ 4,130,145	\$ 3,223,740			\$ 168,906	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.		\$	65,748		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.)		\$	63,835		2														
3. Under or (over) accrual (line 2 minus line 1).		\$	(1,913)		3														
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	65,748		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.)		\$	1,045	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.		\$	64,880		7														
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:	2010	<u>89,232</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> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td style="text-align: center;">16</td> </tr> </table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2014 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
FOR BHF USE ONLY																			
13	FROM R. E. TAX STATEMENT FOR 2014 \$	13																	
14	PLUS APPEAL COST FROM LINE 5 \$	14																	
15	LESS REFUND FROM LINE 6 \$	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																	
	2011	<u>90,082</u>	9																
	2012	<u>66,927</u>	10																
	2013	<u>63,838</u>	11																
	2014	<u>63,835</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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME El Paso Health Care Center COUNTY Woodford
 FACILITY IDPH LICENSE NUMBER 0050914
 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 2014 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 2014.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>16-04-301-024</u>	<u>Long-Term Care Facility</u>	\$ <u>61,263.98</u>	\$ <u>61,263.98</u>
2. <u>16-04-302-017</u>	<u>Long-Term Care Facility</u>	\$ <u>2,571.42</u>	\$ <u>2,571.42</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>63,835.40</u></u>	\$ <u><u>63,835.40</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

Attach a copy of the original 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: 33,000 B. General Construction Type: Exterior Brick & Block Frame Steel 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: 561,304 2. Number of Years Over Which it is Being Amortized: 20
 3. Current Period Amortization: 30,470 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>202,500</u>	<u>2004</u>	<u>\$ 50,000</u>	1
2					2
3	TOTALS	<u>202,500</u>		<u>\$ 50,000</u>	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	123	2004	1974	\$ 934,850	\$	35	\$ 26,710	\$ 26,710	\$ 271,552
5									
6									
7									
8									
Improvement Type**									
9	Sidewalks		2006	7,230		15	482	482	4,579
10	Windows		2006	7,500		25	300	300	2,850
11	Generator		2007	17,756		15	1,184	1,184	10,064
12	Office air conditioner repair		2008	3,125		15	208	208	1,560
13	Water Heater		2010	9,172		10	918	918	5,049
14	Air Conditioner		2010	7,150		15	476	476	2,618
15	Fencing		2011	7,048		25	282	282	1,269
16	Chair Rail		2013	3,604		7	514	514	1,285
17	Boiler		2014	9,662		15	644	644	966
18	Air Conditoner		2014	6,500		15	433	433	650
19	Landscaping		2014	10,246		15	683	683	1,025
20	Landscaping		2015	11,928		7	852	852	852
21	Air Conditioner		2015	5,829		15	195	195	195
22									
23									
24									
25									
26									
27									
28									
29	Land Improvements Booked				282			(282)	
30	Building Booked				37,457			(37,457)	
31	Building Improvement Booked				6,173			(6,173)	
32									
33	2015-Home Office Allocation-Building Improvements			18,003			432	432	
34	2015-Home Office Allocation-Land Improvements			1,681			107	107	
35									
36									

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number El Paso Health Care Center

0050914

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,061,284	\$ 43,912		\$ 34,420	\$ (9,493)	\$ 304,514	70

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

Facility Name & ID Number El Paso Health Care Center

0050914

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

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	\$ 56,334	\$ 4,506	\$ 5,247	\$ 741	5-10 yrs.	\$ 31,819	71
72	Current Year Purchases	3,806	45	190	145	10 yrs.	190	72
73	Fully Depreciated Assets	273,582					273,582	73
74	Home Office Allocation			16,746	16,746			74
75	TOTALS	\$ 333,722	\$ 4,551	\$ 22,183	\$ 17,632		\$ 305,591	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)	\$ 1,445,006	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 48,463	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 56,603	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 8,140	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 610,105	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.

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: \$ 7,238 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	\$ 572	\$ 6,863	17
18	Facility	2012 Ford E250	822	9,864	18
19					19
20					20
21	TOTAL		\$ #####	\$ 16,727	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.

El Paso Health Care Center

0050914

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	\$	1,625
Dishwasher		1,329
Copier		3,073
Home Office Allocation		<u>1,211</u>
		<u><u>7,238</u></u>

Facility Name & ID Number El Paso Health Care Center # 0050914 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? <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	10A(3)	hrs	\$	2,834	\$ 42,514	\$	2,834	\$ 42,514	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,186	17,794		1,186	17,794	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		2,669	40,036		2,669	40,036	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				31,471		31,471	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	6,689	\$ 100,344	\$ 31,471	6,689	\$ 131,815	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 El Paso Health Care Center

0050914

Report 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 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 1,811,835	\$ 1,811,835	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>96,164</u>)	1,299,168	1,299,168	3
4	Supply Inventory (priced at <u>Cost</u>)	15,035	15,035	4
5	Short-Term Investments			5
6	Prepaid Insurance	41,353	41,353	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Prepaid Expenses</u>	45,314	45,314	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,212,705	\$ 3,212,705	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	64,278	50,000	13
14	Buildings, at Historical Cost	934,850	952,853	14
15	Leasehold Improvements, at Historical Cost	92,472	108,431	15
16	Equipment, at Historical Cost	333,722	333,722	16
17	Accumulated Depreciation (book methods)	(776,032)	(610,105)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 649,290	\$ 834,901	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,861,995	\$ 4,047,606	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 403,899	\$ 403,899	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	110,235	110,235	30
31	Accrued Taxes Payable (excluding real estate taxes)	60,339	60,339	31
32	Accrued Real Estate Taxes(Sch.IX-B)	65,748	65,748	32
33	Accrued Interest Payable	13,175	13,175	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Payroll Withholdings</u>	28,868	28,868	36
37	<u>Accrued Management Fees</u>	32,857	32,857	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 715,121	\$ 715,121	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	3,223,740	3,223,740	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>Intercompany Loans</u>	35,493	35,493	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,259,233	\$ 3,259,233	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,974,354	\$ 3,974,354	46
47	TOTAL EQUITY(page 18, line 24)	\$ (112,359)	\$ 73,252	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,861,995	\$ 4,047,606	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (733,583)	1
2	Restatements (describe):		2
3	Prior Period Adjustment Made After Cost Report Was Filed	78,873	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (654,710)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	542,351	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)	\$ 542,351	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)	\$ (112,359)	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	\$ 4,625,466	1
2	Discounts and Allowances for all Levels	(107,414)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,518,052	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	157,122	6
7	Oxygen	387	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 157,509	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	603	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	44,354	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	2,845	20
21	Other Medical Services	1,650	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 49,452	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	12,226	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 12,226	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Transportation Revenue	12,121	28
28a	Miscellaneous Revenue	5,102	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 17,223	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,754,462	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	960,037	31
32	Health Care	1,806,202	32
33	General Administration	738,476	33
B. Capital Expense			
34	Ownership	291,350	34
C. Ancillary Expense			
35	Special Cost Centers	102,818	35
36	Provider Participation Fee	313,228	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,212,111	40
41	Income before Income Taxes (line 30 minus line 40)**	542,351	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 542,351	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 4,288,780	44
45	Private Pay - Net Inpatient Revenue	114,906	45
46	Medicare - Net Inpatient Revenue	81,649	46
47	Other-(specify) <u>Veterans -Net Patient Revenue</u>	34,268	47
48	Other-(specify) <u>Charity and Insurance Contractual Allowance</u>	(1,551)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,518,052	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 El Paso Health Care Center

0050914

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	2,080	2,080	\$ 75,784	\$ 36.43	1
2	Assistant Director of Nursing	2,080	2,080	59,516	28.61	2
3	Registered Nurses	6,413	6,465	175,786	27.19	3
4	Licensed Practical Nurses	17,415	17,804	423,293	23.78	4
5	CNAs & Orderlies	42,962	44,359	574,254	12.95	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,091	1,179	18,658	15.83	9
10	Activity Assistants	7,393	7,473	63,342	8.48	10
11	Social Service Workers	9,085	9,246	106,797	11.55	11
12	Dietician					12
13	Food Service Supervisor	2,009	2,009	32,949	16.40	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,955	17,514	153,056	8.74	15
16	Dishwashers					16
17	Maintenance Workers	3,656	3,843	48,571	12.64	17
18	Housekeepers	12,923	13,151	119,790	9.11	18
19	Laundry	6,609	6,844	59,064	8.63	19
20	Administrator	2,080	2,080	65,833	31.65	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,642	3,870	60,135	15.54	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,927	2,071	55,970	27.03	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>See PG20A</u>	4,258	4,467	74,297	16.63	33
34	TOTAL (lines 1 - 33)	142,578	146,535	\$ 2,167,095 *	\$ 14.79	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 24,250	L9,C3	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 8,979	L10, C3	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant	4 215	L10A, C3	42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	4 \$ 33,444		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	72 \$ 2,382	L10, C3	50
51	Licensed Practical Nurses	120 3,974	L10, C3	51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)	192 \$ 6,357		53

El Paso Health Care Center

0050914

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	2,178	2,387	38,891	16.29
Marketing	2,080	2,080	35,406	17.02
TOTAL	4,258	4,467	74,297	

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	
Michelle Pollard	Administrator	0	\$ 65,833	Workers' Compensation Insurance	\$ 64,394	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance	49,754	Advertising: Employee Recruitment	2,848	
				FICA Taxes	153,420	Health Care Worker Background Check		
				Employee Health Insurance	(5,514)	(Indicate # of checks performed <u>713</u>)	8,482	
				Employee Meals		Miscellaneous Licenses & Permits	197	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Dues & Subscriptions		
				Employee Relations	850	Home Office Allocation	3,499	
				Employee Retirement	861			
				Home Office Allocation	61,490			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 65,833	TOTAL (agree to Schedule V, line 22, col.8)		\$ 17,016		
B. Administrative - Other							Less: Public Relations Expense ()	
Description			Amount				Non-allowable advertising ()	
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 315,600				Yellow page advertising ()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 315,600	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description			Description	
Vendor/Payee	Type	Amount		Description	Line #	Amount	Amount	
E-Health Data Solutions	Computer Services	\$ 4,026					Out-of-State Travel \$	
Fairpoint Communications	Computer Services	491						
Mediacom	Computer Services	1,523						
Honkamp Kreuger	Accounting Services	1,365		N/A			In-State Travel	
Lancaster Pollard	Consulting Fees	1,537						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 8,942	TOTAL			\$	Seminar Expense
								Home Office Allocation 140
								Entertainment Expense ()
								TOTAL (agree to Sch. V, line 24, col. 8)
								\$ 140

* Attach copy of IMRF notifications

**See instructions.

El Paso Health Care Center
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Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		8,942
Home Office Allocation		
Denton's US LLP	Legal	200
Applegate and Thorne	Legal	31
Miller Hall and Triggs	Legal	30
Healthcare Resources International	Legal	164
Lexis Nexis	Legal	12
GoffWilson	Legal	1372
Duane Morris LLP	Legal	5927
Miscellaneous	Legal	93
CliftonLarson Allen	Accountants	2,141
Ginoli & Co.	Accountants	4,252
Miscellaneous	Computer Services	98
CCH	Computer Services	24
PTC Select	Computer Services	33
Advanced Answers on Demand	Computer Services	4391
Stratus Networks	Computer Services	798
Kemper Technology	Computer Services	1175
AT&T	Computer Services	10
Ability Network	Computer Services	1131
CIAN	Computer Services	796
Comcast	Computer Services	30
Emdeon	Computer Services	66
Charter Communications	Computer Services	54
Allscripts	Computer Services	39
Allpayer Exchange	Computer Services	25
E-Health Technologies	Computer Services	17

Macquarie Technology Services	Computer Services	27
Optimizer	Other Prof Fees	77
D.J. Howard Appraisers	Other Prof Fees	70
Key Corporate Services	Other Prof Fees	233
Consolidated Land Surveying	Other Prof Fees	147
Alan Litwiller	Other Prof Fees	30
Marotta Gund Budd & Derza	Other Prof Fees	62848
Private Bank	Other Prof Fees	3325
Total (agree to Schedule V, line 19, column 8)		<u>98,608</u>

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 El Paso Health Care Center

0050914

Report Period Beginning:

1/1/2015

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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. \$ 13,502 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. \$ 313,228
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. \$ 603
- (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. \$ 12,121
- 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.