FOR BHF USE

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

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

I. IDPH License ID Number: 0053157

Facility Name: Enfield Rehab & Hlth Care Ct

Address: 408 North Wilson St (Number) Enfield (City) 62835 (Zip Code)

County: White

Telephone Number: (618) 963-2331 **Fax #** (618) 963-2083

HFS ID Number:

Date of Initial License for Current Owners: 10/01/2005

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Mike Kocher **Telephone Number:** (309)689-5850
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2015 to 12/31/2015 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

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

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

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

Facility Name & ID Number Enfield Rehab & Hlth Care Ct # 0053157 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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	23	Skilled (SNF)	23	8,395	1
2		Skilled Pediatric (SNF/PED)			2
3	24	Intermediate (ICF)	24	8,760	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	47	TOTALS	47	17,155	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF		1,701	839	2,540	8
9	SNF/PED					9
10	ICF	6,747			6,747	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	6,747	1,701	839	9,287	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 54.14%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

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

I. On what date did you start providing long term care at this location?
Date started 10/1/2005

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/1/2005 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 23 and days of care provided 815

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number Enfield Rehab & Hlth Care Ct # 0053157 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 Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	93,906	8,057	2,237	104,200		104,200	1,800	106,000			1
2	Food Purchase		69,555		69,555		69,555	(666)	68,889			2
3	Housekeeping	45,405	14,291		59,696		59,696	14	59,710			3
4	Laundry		2,852		2,852		2,852		2,852			4
5	Heat and Other Utilities			37,924	37,924		37,924	104	38,028			5
6	Maintenance	24,260	3,210	11,190	38,660		38,660	714	39,374			6
7	Other (specify):* Home Office Ben. Allocation											7
8	TOTAL General Services	163,571	97,965	51,351	312,887		312,887	1,966	314,853			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	421,318	42,491	2,545	466,354		466,354	(1,443)	464,911			10
10a	Therapy			61,336	61,336		61,336		61,336			10a
11	Activities	25,198	41		25,239		25,239	(3,360)	21,879			11
12	Social Services	26,652			26,652		26,652		26,652			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Office Ben. Allocation											15
16	TOTAL Health Care and Programs	473,168	42,532	69,881	585,581		585,581	(4,803)	580,778			16
	C. General Administration											
17	Administrative			139,700	139,700		139,700	(79,158)	60,542			17
18	Directors Fees											18
19	Professional Services			15,590	15,590		15,590	5,828	21,418			19
20	Dues, Fees, Subscriptions & Promotions			3,020	3,020		3,020	503	3,523			20
21	Clerical & General Office Expenses	6,229	1,192	8,290	15,711		15,711	20,108	35,819			21
22	Employee Benefits & Payroll Taxes			87,754	87,754		87,754	13,534	101,288			22
23	Inservice Training & Education							139	139			23
24	Travel and Seminar							32	32			24
25	Other Admin. Staff Transportation			5,294	5,294		5,294	1,416	6,710			25
26	Insurance-Prop.Liab.Malpractice			14,888	14,888		14,888	218	15,106			26
27	Other (specify):* Home Office Ben. Allocation											27
28	TOTAL General Administration	6,229	1,192	274,536	281,957		281,957	(37,380)	244,577			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	642,968	141,689	395,768	1,180,425		1,180,425	(40,217)	1,140,208			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Enfield Rehab & Hlth Care Ct #0053157 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			19,380	19,380		19,380	5,586	24,966			30
31	Amortization of Pre-Op. & Org.							3,645	3,645			31
32	Interest			1,566	1,566		1,566	16,542	18,108			32
33	Real Estate Taxes			7,224	7,224		7,224	236	7,460			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			23,803	23,803		23,803	273	24,076			35
36	Other (specify):* Home Office Ben. Allocation											36
37	**TOTAL Ownership**			51,973	51,973		51,973	26,282	78,255			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		13,229		13,229		13,229		13,229			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			76,972	76,972		76,972		76,972			42
43	Other (specify):* Home Office Ben. Allocati		379	46,126	46,505		46,505	(46,505)				43
44	**TOTAL Special Cost Centers**		13,608	123,098	136,706		136,706	(46,505)	90,201			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	642,968	155,297	570,839	1,369,104		1,369,104	(60,440)	1,308,664			45

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

Facility Name & ID Number Enfield Rehab & Hlth Care Ct # 0053157 Report Period Beginning: 1/1/2015 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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(669)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,040)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	2,002	30		9
10	Interest and Other Investment Income	(17)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(34)	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	(38,729)	43		18
19	Entertainment				19
20	Contributions		43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,818)	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	(6,812)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (50,117)		$	30

BHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(10,323)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (10,323)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (60,440)		37

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

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

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

Enfield Rehab & Hlth Care Ct

ID# 0053157

Report Period Beginning: 1/1/2015

Ending: 12/31/2015

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Offset Miscellaneous Nursing Supplies Revenue	$ (1,498)	10	1
2	Resident Flowers	(109)	43	2
3	Offset Transportation Revenue	(3,360)	11	3
4	Disallow Special events	3	43	4
5	X-Rays Part A	(1,477)	43	5
6	Labs Part A	(301)	43	6
7	Offset Miscellaneous Office Supplies Revenue	(70)	21	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(6,812)		49

Facility Name & ID Number Enfield Rehab & Hlth Care Ct # 0053157 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
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%	91	91	12
13	V								13
14	Total			$			$ 91	$ * 91	14

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

Facility Name & ID Number Enfield Rehab & Hlth Care Ct # 0053157 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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	20	Dues, Fees, Subs & Promotions	$	Petersen Health Care, Inc.	100.00%	$ 24	$ 24	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%	352	352	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			$			$ 376	$ * 376	39

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

Facility Name & ID Number Enfield Rehab & Hlth Care Ct # 0053157 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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Petersen Health 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%	2,553	2,553	25
26	V	20	Dues, Fees, Subs & Promotions		Petersen Health Wellness, LLC	100.00%	422	422	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%	40	40	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%	3,645	3,645	34
35	V	32	Interest		Petersen Health Wellness, LLC	100.00%	16,455	16,455	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			$			$ 23,115	$ * 23,115	39

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

Facility Name & ID Number Enfield Rehab & Hlth Care Ct # 0053157 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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Petersen Health Care Management, Inc.	100.00%	$ 1,800	$ 1,800	15
16	V	2	Food		Petersen Health Care Management, Inc.	100.00%	3	3	16
17	V	3	Housekeeping		Petersen Health Care Management, Inc.	100.00%	14	14	17
18	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	104	104	18
19	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	714	714	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%	55	55	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	139,700	Petersen Health Care Management, Inc.	100.00%	60,542	(79,158)	25
26	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	3,184	3,184	26
27	V	20	Dues, Fees, Subs & Promotions		Petersen Health Care Management, Inc.	100.00%	57	57	27
28	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	20,178	20,178	28
29	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	13,494	13,494	29
30	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	139	139	30
31	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	32	32	31
32	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	1,416	1,416	32
33	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	218	218	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%	3,232	3,232	35
36	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	104	104	36
37	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	236	236	37
38	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	273	273	38
39	Total			$ 139,700			$ 105,795	$ * (33,905)	39

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

Facility Name & ID Number Enfield Rehab & Hlth Care Ct # 0053157 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, L	Peoria	Mgmt/Bookkeeping	1
2			Arcola Health Care Center	Arcola	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	2
3			Aspen Rehab & Health Care	Silvis	Petersen Health Care,	Peoria	Mgmt/Bookkeeping	3
4			Batavia Rehab & Health Care Center	Batavia	Petersen Health Enter	Peoria	Mgmt/Bookkeeping	4
5			Bement Health Care Center	Bement	Petersen Health Opera	Peoria	Mgmt/Bookkeeping	5
6			Benton Rehab & Health Care Center	Benton	Petersen Health Syster	Peoria	Mgmt/Bookkeeping	6
7			Bloomington Rehab & Health Care Center	Bloomington	Petersen Hotels LLC	Peoria	Hospitality	7
8			Casey Health Care Center	Casey	Petersen Hospitality L	Peoria	Hospitality	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Health Care Y	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Care Y	Peoria	Mgmt/Bookkeeping	11
12			Countryview Terrace	Louisville	Petersen Health Care Y	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care Y	Peoria	Mgmt/Bookkeeping	13
14			Decatur Rehab & Health Care Center	Decatur	Petersen Health Care I	Peoria	Lessor	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Osage Beach,	Osage Beach. MO	Lessor	15
16			Eastview Terrace	Sullivan	Petersen West Frankfo	West Frankfort	Lessor	16
17			El Paso Health Care Center	El Paso	Midwest Health Care,	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	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 Enfield Rehab & Hlth Care Ct # 0053157 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 Enfield Rehab & Hlth Care Ct # 0053157 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 Enfield Rehab & Hlth Care Ct # 0053157 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 Enfield Rehab & Hlth Care Ct # 0053157 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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3	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 Enfield Rehab & Hlth Care Ct # 0053157 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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	1,553,881	75	$ 0	$ 0	9,287	$ 0	1
2	2	Food	Resident Days	1,553,881	75	0	0	9,287	0	2
3	3	Housekeeping	Resident Days	1,553,881	75	0	0	9,287	0	3
4	5	Utilities	Resident Days	1,553,881	75	0	0	9,287	0	4
5	6	Maintenance	Resident Days	1,553,881	75	0	0	9,287	0	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75	0	0	9,287	0	6
7	9	Medical Director	Resident Days	1,553,881	75	0	0	9,287	0	7
8	10	Nursing and Medical Records	Resident Days	1,553,881	75	0	0	9,287	0	8
9	10A	Therapy	Resident Days	1,553,881	75	0	0	9,287	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75	0	0	9,287	0	10
11	17	Administrative	Resident Days	1,553,881	75	0	0	9,287	0	11
12	19	Professional Services	Resident Days	1,553,881	75	15,159	0	9,287	91	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,553,881	75	4,077	0	9,287	24	13
14	21	Clerical and General Office	Resident Days	1,553,881	75	0	0	9,287	0	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,553,881	75	0	0	9,287	0	15
16	23	Inservice Training & Education	Resident Days	1,553,881	75	0	0	9,287	0	16
17	24	Travel and Seminar	Resident Days	1,553,881	75	0	0	9,287	0	17
18	25	Other Admin. Staff Transport.	Resident Days	1,553,881	75	0	0	9,287	0	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,553,881	75	0	0	9,287	0	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75	0	0	9,287	0	20
21	30	Depreciation	Resident Days	1,553,881	75	58,874	0	9,287	352	21
22	32	Interest	Resident Days	1,553,881	75	0	0	9,287	0	22
23	33	Real Estate Taxes	Resident Days	1,553,881	75	0	0	9,287	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,553,881	75	0	0	9,287	0	24
25	TOTALS					$ 78,110	$		$ 467	25

Facility Name & ID Number Enfield Rehab & Hlth Care Ct # 0053157 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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	111,418	11	$	$	9,287	$	1
2	2	Food	Resident Days	111,418	11			9,287		2
3	3	Housekeeping	Resident Days	111,418	11			9,287		3
4	4	Laundry	Resident Days	111,418	11			9,287		4
5	5	Utilities	Resident Days	111,418	11			9,287		5
6	6	Maintenance	Resident Days	111,418	11			9,287		6
7	7	Mgmt. Allocation of Benefits	Resident Days	111,418	11			9,287		7
8	10	Nursing and Medical Records	Resident Days	111,418	11			9,287		8
9	15	Mgmt. Allocation of Benefits	Resident Days	111,418	11			9,287		9
10	17	Administrative	Resident Days	111,418	11			9,287		10
11	19	Professional Services	Resident Days	111,418	11	30,633		9,287	2,553	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	111,418	11	5,064		9,287	422	12
13	21	Clerical and General Office	Resident Days	111,418	11			9,287		13
14	22	Employee Benefits & Payroll	Resident Days	111,418	11	484		9,287	40	14
15	23	Inservice Training & Education	Resident Days	111,418	11			9,287		15
16	24	Travel and Seminar	Resident Days	111,418	11			9,287		16
17	25	Other Admin. Staff Transport.	Resident Days	111,418	11			9,287		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	111,418	11			9,287		18
19	30	Depreciation	Resident Days	111,418	11			9,287		19
20	31	Amortization	Resident Days	111,418	11	43,728		9,287	3,645	20
21	32	Interest	Resident Days	111,418	11	197,419		9,287	16,455	21
22	33	Real Estate Taxes	Resident Days	111,418	11			9,287		22
23	34	Rent-Facility and Grounds	Resident Days	111,418	11			9,287		23
24	35	Rent-Equipment & Vehicles	Resident Days	111,418	11			9,287		24
25	TOTALS					$ 277,328	$		$ 23,115	25

Facility Name & ID Number Enfield Rehab & Hlth Care Ct # 0053157 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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	1,553,881	75	$ 301,135	$ 292,840	9,287	$ 1,800	1
2	2	Food	Resident Days	1,553,881	75	480		9,287	3	2
3	3	Housekeeping	Resident Days	1,553,881	75	2,362	2,362	9,287	14	3
4	5	Utilities	Resident Days	1,553,881	75	17,327		9,287	104	4
5	6	Maintenance	Resident Days	1,553,881	75	119,427	88,000	9,287	714	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75			9,287		6
7	9	Medical Director	Resident Days	1,553,881	75			9,287		7
8	10	Nursing and Medical Records	Resident Days	1,553,881	75	9,192		9,287	55	8
9	10A	Therapy	Resident Days	1,553,881	75			9,287		9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75			9,287		10
11	17	Administrative	Resident Days	1,553,881	75	4,799,018	4,755,666	9,287	60,542	11
12	19	Professional Services	Resident Days	1,553,881	75	532,666		9,287	3,184	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,553,881	75	9,548		9,287	57	13
14	21	Clerical and General Office	Resident Days	1,553,881	75	3,376,139	3,043,176	9,287	20,178	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,553,881	75	2,257,824		9,287	13,494	15
16	23	Inservice Training & Education	Resident Days	1,553,881	75	23,223		9,287	139	16
17	24	Travel and Seminar	Resident Days	1,553,881	75	5,279		9,287	32	17
18	25	Other Admin. Staff Transport.	Resident Days	1,553,881	75	236,965		9,287	1,416	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,553,881	75	36,398		9,287	218	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75			9,287		20
21	30	Depreciation	Resident Days	1,553,881	75	540,826		9,287	3,232	21
22	32	Interest	Resident Days	1,553,881	75	17,439		9,287	104	22
23	33	Real Estate Taxes	Resident Days	1,553,881	75	39,471		9,287	236	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,553,881	75	45,727		9,287	273	24
25	TOTALS					$ 12,370,446	$ 8,182,044		$ 105,795	25

Facility Name & ID Number Enfield Rehab & Hlth Care Ct # 0053157 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	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	The Private Bank		X	Mortgage	Varies	9/14/14	$ 89,186	$ Retired			$ 1,566	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 89,186	$			$ 1,566	9
	B. Non-Facility Related*											
10												10
11								Interest Income Offset			(17)	11
12								Home Office Allocation-PHW			16,455	12
13								Home Office Allocation-PHCM			104	13
14	TOTAL Non-Facility Related						$	$			$ 16,542	14
15	TOTALS (line 9+line14)						$ 89,186	$			$ 18,108	15

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

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Enfield Rehab & Hlth Care Ct # 0053157 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 6,900	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.)		$ 6,960	2
3. Under or (over) accrual (line 2 minus line 1).		$ 60	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 7,164	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **Home Office Allocation**		236	
TOTAL REFUND $ For Tax Year. **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 7,460	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	6,482	8
	2011	6,561	9
	2012	6,802	10
	2013	6,701	11
	2014	6,960	12

Accrual based on prior year tax bill.

	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

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 Enfield Rehab & Hlth Care Ct COUNTY White

FACILITY IDPH LICENSE NUMBER 0053157

CONTACT PERSON REGARDING THIS REPORT MARK PETERSEN

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

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

Enter the tax index number and real estate tax assessed for 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) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	EN-10-170-5	Long-Term Care Facility	$ 6,960.00	$ 6,960.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 6,960.00	$ 6,960.00

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.

Facility Name & ID Number Enfield Rehab & Hlth Care Ct # 0053157 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 10,476 B. General Construction Type: Exterior Brick & Concrete Frame Wood Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

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

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

N/A

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

1. Total Amount Incurred: 99,556
2. Number of Years Over Which it is Being Amortized: 20
3. Current Period Amortization: 3,645
4. Dates Incurred: 2013-2014

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	75,359	2005	$ 15,750	1
2					2
3	TOTALS	75,359		$ 15,750	3

Facility Name & ID Number Enfield Rehab & Hlth Care Ct # 0053157 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 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	49		2005	1972	$ 290,250	$	25	$ 11,610	$ 11,610	$ 124,167	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Door Alarm			2007	1,636		15	109	109	927	9
10	Air Compressor			2007	1,302		15	87	87	739	10
11	New Roof			2007	29,725		20	1,486	1,486	12,631	11
12	Awning			2008	2,569		20	128	128	960	12
13	Sprinkler System			2011	2,990		7	428	428	1,926	13
14	Sidewalk and Pavement Replacement			2013	35,360		25	1,414	1,414	3,535	14
15	Ceramic and vinyl tile installment-Main Hallways			2014	20,489		15	1,366	1,366	2,049	15
16	Water Heater			2014	14,671		7	2,096	2,096	3,144	16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28	Land Improvements Booked					667			(667)		28
29	Building Booked					11,253			(11,253)		29
30	Building Improvement Booked					6,194			(6,194)		30
31											31
32	2015-Home Office Allocation-Building Improvements				4,064			97	97		32
33	2015-Home Office Allocation-Land Improvements				379			24	24		33
34											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

Facility Name & ID Number Enfield Rehab & Hlth Care Ct # 0053157 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)		$ 403,435	$ 18,114		$ 18,845	$ 731	$ 150,078	70

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

Facility Name & ID Number Enfield Rehab & Hlth Care Ct # 0053157 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	$ 31,917	$ 1,266	$ 2,658	$ 1,392	5-10 yrs.	$ 19,270	71
72	Current Year Purchases					10 yrs.		72
73	Fully Depreciated Assets	58,420					58,420	73
74	Home Office Allocation			3,463	3,463			74
75	TOTALS	$ 90,337	$ 1,266	$ 6,121	$ 4,855		$ 77,690	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 509,522	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 19,380	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 24,966	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 5,586	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 227,768	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88	N/A				88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93	N/A		93
94			94
95		$	95

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

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

Facility Name & ID Number Enfield Rehab & Hlth Care Ct # 0053157 Report Period Beginning: 1/1/2015 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

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2016	$
13.	/2017	$
14.	/2018	$

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: $ 17,138 Description: See Attached Schedule 14A
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Enfield Rehab & Hlth Care Ct
0053157
Period Beginning 1/1/2015
Period End 12/31/2015

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	$	7,258
Dishwasher		711
Copier		8,896
Home Office Allocation		273
		17,138

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Enfield Rehab & Hlth Care Ct # 0053157 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A(3)	hrs	$	183	$ 28,391	$	183	$ 28,391	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		299	4,489		299	4,489	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		1,897	28,456		1,897	28,456	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				13,229		13,229	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			$	2,379	$ 61,336	$ 13,229	2,379	$ 74,565	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Enfield Rehab & Hlth Care Ct # 0053157 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	$ (262,103)	$ (262,103)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 37,126)	414,985	414,985	3
4	Supply Inventory (priced at Cost)	5,203	5,203	4
5	Short-Term Investments			5
6	Prepaid Insurance	16,036	16,036	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 174,121	$ 174,121	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	25,750	15,750	13
14	Buildings, at Historical Cost	280,250	294,314	14
15	Leasehold Improvements, at Historical Cost	108,742	109,121	15
16	Equipment, at Historical Cost	84,998	90,337	16
17	Accumulated Depreciation (book methods)	(223,786)	(227,768)	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)**	$ 275,954	$ 281,754	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 450,075	$ 455,875	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 277,486	$ 277,486	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	38,662	38,662	30
31	Accrued Taxes Payable (excluding real estate taxes)	37,289	37,289	31
32	Accrued Real Estate Taxes(Sch.IX-B)	7,164	7,164	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	13,468	13,468	36
37	Accrued Management Fees	331,966	331,966	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 706,035	$ 706,035	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	Intercompany Loans	17	17	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 17	$ 17	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 706,052	$ 706,052	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (255,977)	$ (250,177)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 450,075	$ 455,875	48

*(See instructions.)

Facility Name & ID Number Enfield Rehab & Hlth Care Ct # 0053157 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (287,501)	1	
2	Restatements (describe):		2	
3	**Prior Period Adjustment Made After Cost Report Was Filed**	785	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (286,716)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	30,739	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)**	$ 30,739	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)**	$ (255,977)	24	*

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

Facility Name & ID Number Enfield Rehab & Hlth Care Ct # 0053157 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,324,941	1
2	Discounts and Allowances for all Levels	(75,876)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,249,065	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	107,706	6
7	Oxygen	14	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 107,720	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	669	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	33,459	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	2,037	20
21	Other Medical Services	1,948	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 38,113	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	17	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 17	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Transportation Revenue	3,360	28
28a	Miscellaneous Revenue	1,568	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,928	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,399,843	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	312,887	31
32	Health Care	585,581	32
33	General Administration	281,957	33
	B. Capital Expense		
34	Ownership	51,973	34
	C. Ancillary Expense		
35	Special Cost Centers	59,734	35
36	Provider Participation Fee	76,972	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,369,104	40
41	**Income before Income Taxes (line 30 minus line 40)****	30,739	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 30,739	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 849,224	44
45	Private Pay - Net Inpatient Revenue	219,817	45
46	Medicare - Net Inpatient Revenue	171,444	46
47	Other-(specify) Insurance Net Inpatient Revenue	9,189	47
48	Other-(specify) Charity Contractual Allowance	(609)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 1,249,065	49

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

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

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

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

Facility Name & ID Number Enfield Rehab & Hlth Care Ct # 0053157 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,860	1,860	$ 47,702	$ 25.65	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,084	2,155	44,866	20.82	3
4	Licensed Practical Nurses	8,279	8,477	143,357	16.91	4
5	CNAs & Orderlies	17,647	18,009	185,393	10.29	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	886	924	11,206	12.13	9
10	Activity Assistants	644	644	6,738	10.46	10
11	Social Service Workers	1,974	2,046	26,652	13.03	11
12	Dietician					12
13	Food Service Supervisor	1,866	2,052	28,008	13.65	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,479	6,764	65,898	9.74	15
16	Dishwashers					16
17	Maintenance Workers	1,717	1,813	24,260	13.38	17
18	Housekeepers	4,775	5,102	45,405	8.90	18
19	Laundry					19
20	Administrator	2,080	2,080	60,542	29.11	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	381	381	6,229	16.35	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Transportation	682	685	7,254	10.59	33
34	TOTAL (lines 1 - 33)	51,354	52,992	$ 703,510 *	$ 13.28	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	40	$ 2,237	L1, C3	35
36	Medical Director	Monthly	6,000	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,808	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)	40	$ 10,045		49

C. CONTRACT NURSES

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

Facility Name & ID Number Enfield Rehab & Hlth Care Ct # 0053157 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Chastity Harris	Administrator	0	$ 60,542
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 60,542

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 139,700
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 139,700

C. Professional Services

Vendor/Payee	Type	Amount
Hamilton Co. Communications	Computer Services	$ 1,432
E-Health Data Solutions	Computer Services	3,701
Honkamp & Krueger	Accounting Services	2,493
Black, Hedin, Ballard	Legal Services	4,496
Sorling Northrup	Legal Services	3,468
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 15,590

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 24,901
Unemployment Compensation Insurance	21,840
FICA Taxes	48,575
Employee Health Insurance	(8,142)
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	580
Home Office Allocation	13,534
TOTAL (agree to Schedule V, line 22, col.8)	$ 101,288

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

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,826
Advertising: Employee Recruitment	240
Health Care Worker Background Check (Indicate # of checks performed 35)	834
Miscellaneous Licenses & Permits	120
Miscellaneous Dues & Subscriptions	
Home Office Allocation	503
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 3,523

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Home Office Allocation	32
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 32

**See instructions.

Enfield Rehab & Hlth Care Ct
0053157
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)		15,590
Home Office Allocation		
Denton's US LLP	Legal	45
Applegate and Thorne	Legal	7
Miller Hall and Triggs	Legal	7
Healthcare Resources International	Legal	37
Lexis Nexis	Legal	3
GoffWilson	Legal	310
Private Bank	Legal	912
CliftonLarson Allen	Accountants	483
Ginoli & Co.	Accountants	1,529
Private Bank	Accountants	404
Miscellaneous	Computer Services	21
CCH	Computer Services	5
PTC Select	Computer Services	7
Advanced Answers on Demand	Computer Services	991
Stratus Networks	Computer Services	180
Kemper Technology	Computer Services	265
AT&T	Computer Services	2
Ability Network	Computer Services	255
CIAN	Computer Services	180
Comcast	Computer Services	7
Emdeon	Computer Services	15
Charter Communications	Computer Services	12
Allscripts	Computer Services	9
Allpayer Exchange	Computer Services	6
E-Health Technologies	Computer Services	4

Macquarie Technology Services	Computer Services	6
Optimizer	Other Prof Fees	17
D.J. Howard Appraisers	Other Prof Fees	16
Key Corporate Services	Other Prof Fees	53
Consolidated Land Surveying	Other Prof Fees	33
Alan Litwiller	Other Prof Fees	7
Total (agree to Schedule V, line 19, column 8)		21,418

Enfield Rehab & Hlth Care Ct
0053157
Period Beginning **1/1/2015**
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Schedule 21A

XIX. SUPPORT SCHEDULE
Legal Fees

Home Office Allocation-PHC & PHCM		
Denton's US LLP	Legal	45
Applegate and Thorne	Legal	7
Miller Hall and Triggs	Legal	7
Healthcare Resources International	Legal	37
Lexis Nexis	Legal	3
GoffWilson	Legal	310
Private Bank	Legal	912
Direct Facility Invoices		
Black, Hedin, Ballard, McDonald-J. Meyers Case	3/18/2015	288
Sorling Northup-J. Meyers Case	6/8/2015	476
Black, Hedin, Ballard, McDonald-J. Meyers Case	6/10/2015	225
Sorling Northup-J. Meyers Case	7/15/2015	442
Sorling Northup-J. Meyers Case	8/7/2015	112
Black, Hedin, Ballard, McDonald-J. Meyers Case	9/11/2015	3,983
Sorling Northup-J. Meyers Case	9/13/2015	392
Sorling Northup-J. Meyers Case	10/7/2015	336
Sorling Northup-J. Meyers Case	11/9/2015	616
Sorling Northup-J. Meyers Case	12/3/2015	1,095
Total Legal Fees (agree to Schedule V, line 19, column 8)		9,285

Facility Name & ID Number Enfield Rehab & Hlth Care Ct # 0053157 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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

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

Facility Name & ID Number Enfield Rehab & Hlth Care Ct # 0053157 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. $ **7,369** 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. $ **76,972**
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. $ **669**

(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. $ **3,360**
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 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.