		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: 0050922

Facility Name: Farmer City Rehab & Hlth Cr

Address: 404 Brookview Drive (Number) Farmer City (City) 61842 (Zip Code)

County: DeWitt

Telephone Number: (309) 928-2118 **Fax #** (309)928-2313

HFS ID Number:

Date of Initial License for Current Owners: 8/15/1995

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
	IRS Exemption Code		Corporation		Other
		X	"Sub-S" Corp.		
			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 Farmer City Rehab & Hlth Cr # 0050922 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	56	Skilled (SNF)	56	20,440	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	56	TOTALS	56	20,440	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	7,333	8,294	1,703	17,330	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,333	8,294	1,703	17,330	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.78%

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 9/20/2011

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 9/20/2011 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 56 and days of care provided 1,374

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 Farmer City Rehab & Hlth Cr # 0050922 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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	136,357	8,490		144,847		144,847	3,357	148,204			1
2	Food Purchase		107,422		107,422		107,422	(3,175)	104,247			2
3	Housekeeping	43,831	16,996		60,827		60,827	26	60,853			3
4	Laundry	27,834	1,338		29,172		29,172		29,172			4
5	Heat and Other Utilities			41,798	41,798		41,798	193	41,991			5
6	Maintenance	29,663	5,535	19,780	54,978		54,978	1,332	56,310			6
7	Other (specify):* Home Office Ben. Allocation											7
8	**TOTAL General Services**	237,685	139,781	61,578	439,044		439,044	1,733	440,777			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	718,560	54,994	5,576	779,130		779,130	(1,571)	777,559			10
10a	Therapy	27,707		205,353	233,060		233,060		233,060			10a
11	Activities	61,042	666	310	62,018		62,018	(4,708)	57,310			11
12	Social Services	26,890			26,890		26,890		26,890			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Office Ben. Allocation											15
16	**TOTAL Health Care and Programs**	834,199	55,660	217,239	1,107,098		1,107,098	(6,279)	1,100,819			16
	C. General Administration											
17	Administrative			314,100	314,100		314,100	(222,728)	91,372			17
18	Directors Fees											18
19	Professional Services			30,097	30,097		30,097	4,108	34,205			19
20	Dues, Fees, Subscriptions & Promotions			2,929	2,929		2,929	151	3,080			20
21	Clerical & General Office Expenses	48,739	3,873	8,224	60,836		60,836	37,642	98,478			21
22	Employee Benefits & Payroll Taxes			106,221	106,221		106,221	25,174	131,395			22
23	Inservice Training & Education							259	259			23
24	Travel and Seminar							59	59			24
25	Other Admin. Staff Transportation			10,405	10,405		10,405	2,642	13,047			25
26	Insurance-Prop.Liab.Malpractice			1,549	1,549		1,549	22,905	24,454			26
27	Other (specify):* Home Office Ben. Allocation											27
28	**TOTAL General Administration**	48,739	3,873	473,525	526,137		526,137	(129,788)	396,349			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,120,623	199,314	752,342	2,072,279		2,072,279	(134,334)	1,937,945			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	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			20,456	20,456		20,456	36,825	57,281			30
31	Amortization of Pre-Op. & Org.							1,110	1,110			31
32	Interest							52,669	52,669			32
33	Real Estate Taxes							28,432	28,432			33
34	Rent-Facility & Grounds			191,650	191,650		191,650	(191,650)				34
35	Rent-Equipment & Vehicles			12,344	12,344		12,344	510	12,854			35
36	Other (specify):* Home Office Ben. Allocation											36
37	**TOTAL Ownership**			224,450	224,450		224,450	(72,104)	152,346			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		34,046		34,046		34,046		34,046			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			125,060	125,060		125,060		125,060			42
43	Other (specify):* Home Office Ben. Allocati		189	50,716	50,905		50,905	(50,905)				43
44	**TOTAL Special Cost Centers**		34,235	175,776	210,011		210,011	(50,905)	159,106			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,120,623	233,549	1,152,568	2,506,740		2,506,740	(257,343)	2,249,397			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 Farmer City Rehab & Hlth Cr # 0050922 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	(3,180)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,645)	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	(24,912)	30		9
10	Interest and Other Investment Income	(666)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(209)	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	(37,326)	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	(1,942)	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**	(15,261)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (90,141)		$	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)	(167,202)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (167,202)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (257,343)		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

STATE OF ILLINOIS

Farmer City Rehab & Hlth Cr

ID# 0050922

Report Period Beginning: 1/1/2015

Ending: 12/31/2015

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Pet Expense	$ (1,234)	43	1
2	Labs-Part A	(1,379)	43	2
3	X-Rays-Part A	(4,229)	43	3
4	Offset Miscellaneous Nursing Supplies Income	(1,674)	10	4
5	Offset Transportation Revenue	(4,708)	11	5
6	Disallowed Legal Settlement	(2,000)	19	6
7	Resident Flowers	(37)	43	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**	(15,261)		49

Facility Name & ID Number Farmer City Rehab & Hlth Cr # 0050922 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%	169	169	12
13	V								13
14	Total			$			$ 169	$ * 169	14

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

Facility Name & ID Number Farmer City Rehab & Hlth Cr # 0050922 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%	$ 45	$ 45	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%	656	656	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			$			$ 701	$ * 701	39

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

Facility Name & ID Number Farmer City Rehab & Hlth Cr # 0050922 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	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%	$ 3,357	$ 3,357	15
16	V	2	Food		Petersen Health Care Management, Inc.	100.00%	5	5	16
17	V	3	Housekeeping		Petersen Health Care Management, Inc.	100.00%	26	26	17
18	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	193	193	18
19	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	1,332	1,332	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%	103	103	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	314,100	Petersen Health Care Management, Inc.	100.00%	91,372	(222,728)	25
26	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	5,939	5,939	26
27	V	20	Dues, Fees, Subs & Promotions		Petersen Health Care Management, Inc.	100.00%	106	106	27
28	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	37,642	37,642	28
29	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	25,174	25,174	29
30	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	259	259	30
31	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	59	59	31
32	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	2,642	2,642	32
33	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	406	406	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%	6,030	6,030	35
36	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	194	194	36
37	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	440	440	37
38	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	510	510	38
39	Total			$ 314,100			$ 175,789	$ * (138,311)	39

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

Facility Name & ID Number Farmer City Rehab & Hlth Cr # 0050922 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	21	Clerical and General Office	$	Petersen Health Care, Inc. Farmer City	100.00%	$ 0	$	15
16	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc. Farmer City	100.00%	17,833	17,833	16
17	V	30	Depreciation		Petersen Health Care, Inc. Farmer City	100.00%	55,051	55,051	17
18	V	32	Amortization		Petersen Health Care, Inc. Farmer City	100.00%	1,110	1,110	18
19	V	32	Interest		Petersen Health Care, Inc. Farmer City	100.00%	53,141	53,141	19
20	V	33	Real Estate Taxes		Petersen Health Care, Inc. Farmer City	100.00%	27,992	27,992	20
21	V	34	Rent-Facility and Grounds	191,650	Petersen Health Care, Inc. Farmer City	100.00%	0	(191,650)	21
22	V	43	Service Charges		Petersen Health Care, Inc. Farmer City	100.00%	2,096	2,096	22
23	V	26	Insurance-Mortgage Insurance		Petersen Health Care, Inc. Farmer City	100.00%	4,666	4,666	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 191,650			$ 161,889	$ * (29,761)	39

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

Facility Name & ID Number Farmer City Rehab & Hlth Cr # 0050922 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 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 \	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 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 Farmer City Rehab & Hlth Cr # 0050922 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

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 Farmer City Rehab & Hlth Cr # 0050922 **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 Farmer City Rehab & Hlth Cr # 0050922 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 Farmer City Rehab & Hlth Cr # 0050922 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	17,325	$ 0	1
2	2	Food	Resident Days	1,553,881	75	0	0	17,325	0	2
3	3	Housekeeping	Resident Days	1,553,881	75	0	0	17,325	0	3
4	5	Utilities	Resident Days	1,553,881	75	0	0	17,325	0	4
5	6	Maintenance	Resident Days	1,553,881	75	0	0	17,325	0	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75	0	0	17,325	0	6
7	9	Medical Director	Resident Days	1,553,881	75	0	0	17,325	0	7
8	10	Nursing and Medical Records	Resident Days	1,553,881	75	0	0	17,325	0	8
9	10A	Therapy	Resident Days	1,553,881	75	0	0	17,325	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75	0	0	17,325	0	10
11	17	Administrative	Resident Days	1,553,881	75	0	0	17,325	0	11
12	19	Professional Services	Resident Days	1,553,881	75	15,159	0	17,325	169	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,553,881	75	4,077	0	17,325	45	13
14	21	Clerical and General Office	Resident Days	1,553,881	75	0	0	17,325	0	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,553,881	75	0	0	17,325	0	15
16	23	Inservice Training & Education	Resident Days	1,553,881	75	0	0	17,325	0	16
17	24	Travel and Seminar	Resident Days	1,553,881	75	0	0	17,325	0	17
18	25	Other Admin. Staff Transport.	Resident Days	1,553,881	75	0	0	17,325	0	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,553,881	75	0	0	17,325	0	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75	0	0	17,325	0	20
21	30	Depreciation	Resident Days	1,553,881	75	58,874	0	17,325	656	21
22	32	Interest	Resident Days	1,553,881	75	0	0	17,325	0	22
23	33	Real Estate Taxes	Resident Days	1,553,881	75	0	0	17,325	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,553,881	75	0	0	17,325	0	24
25	TOTALS					$ 78,110	$		$ 870	25

Facility Name & ID Number Farmer City Rehab & Hlth Cr # 0050922 Report Period Beginning: 1/1/2015 Ending: 2/31/2015

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

	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	17,325	$ 3,357	1
2	2	Food	Resident Days	1,553,881	75	480		17,325	5	2
3	3	Housekeeping	Resident Days	1,553,881	75	2,362	2,362	17,325	26	3
4	5	Utilities	Resident Days	1,553,881	75	17,327		17,325	193	4
5	6	Maintenance	Resident Days	1,553,881	75	119,427	88,000	17,325	1,332	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75			17,325		6
7	9	Medical Director	Resident Days	1,553,881	75			17,325		7
8	10	Nursing and Medical Records	Resident Days	1,553,881	75	9,192		17,325	103	8
9	10A	Therapy	Resident Days	1,553,881	75			17,325		9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75			17,325		10
11	17	Administrative	Resident Days	1,553,881	75	4,799,018	4,755,666	17,325	91,372	11
12	19	Professional Services	Resident Days	1,553,881	75	532,666		17,325	5,939	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,553,881	75	9,548		17,325	106	13
14	21	Clerical and General Office	Resident Days	1,553,881	75	3,376,139	3,043,176	17,325	37,642	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,553,881	75	2,257,824		17,325	25,174	15
16	23	Inservice Training & Education	Resident Days	1,553,881	75	23,223		17,325	259	16
17	24	Travel and Seminar	Resident Days	1,553,881	75	5,279		17,325	59	17
18	25	Other Admin. Staff Transport.	Resident Days	1,553,881	75	236,965		17,325	2,642	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,553,881	75	36,398		17,325	406	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75			17,325		20
21	30	Depreciation	Resident Days	1,553,881	75	540,826		17,325	6,030	21
22	32	Interest	Resident Days	1,553,881	75	17,439		17,325	194	22
23	33	Real Estate Taxes	Resident Days	1,553,881	75	39,471		17,325	440	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,553,881	75	45,727		17,325	510	24
25	TOTALS					$ 12,370,446	$ 8,182,044		$ 175,789	25

Facility Name & ID Number Farmer City Rehab & Hlth Cr # 0050922 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	Capmark		X	Mortgage	$9,733.93	11/26/02	$ 1,395,000	$ 909,410	11/26/32	0.0570	$ 53,192	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$9,733.93		$ 1,395,000	$ 909,410			$ 53,192	9
	B. Non-Facility Related*											
10												10
11								Interest Income Offset			(717)	11
12								Home Office Allocation-PHCM			194	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (523)	14
15	TOTALS (line 9+line14)						$ 1,395,000	$ 909,410			$ 52,669	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 4,666 Line # 26

* 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 Farmer City Rehab & Hlth Cr # 0050922 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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.	$	24,665	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.)	$	26,365	2
3. Under or (over) accrual (line 2 minus line 1).	$	1,700	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)	$	26,292	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** 440 **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.	$	28,432	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2010	24,469	8
2011	25,052	9
2012	26,286	10
2013	26,743	11
2014	26,365	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 Farmer City Rehab & Hlth Cr COUNTY DeWitt

FACILITY IDPH LICENSE NUMBER 0050922

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.	05-28-152-006	Long-Term Care Facility	$ 25,526.92	$ 25,526.92
2.	05-28-152-010	Long-Term Care Facility	$ 838.18	$ 838.18
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 26,365.10	$ 26,365.10

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 Farmer City Rehab & Hlth Cr # 0050922 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: B. General Construction Type: Exterior Frame Block Number of Stories 1 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? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 18,042
2. Number of Years Over Which it is Being Amortized: 16
3. Current Period Amortization: 1,110
4. Dates Incurred: 2013

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		2011	$ 101,000	1
2					2
3	TOTALS			$ 101,000	3

Facility Name & ID Number Farmer City Rehab & Hlth Cr # 0050922 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	56		2011	1964	$ 757,118		25	30,285	$ 30,285	$ 136,282	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Sprinkler Repair			2009	3,584		7	512	512	3,328	9
10	Roof			2009	12,850		25	514	514	3,341	10
11	Door-Main Entrance			2009	3,698		10	370	370	2,405	11
12	Fire Alarm Panel			2010	4,728		7	675	675	4,050	12
13	A/C Unit			2010	6,850		15	456	456	2,508	13
14	Water Heater			2011	7,523		7	1,075	1,075	4,837	14
15	Grain Softeners			2011	11,950		7	1,707	1,707	7,682	15
16	Windows			2013	37,540		25	1,502	1,502	3,755	16
17	Roof Replacement			2015	149,875		25	2,998	2,998	2,998	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	Building Booked					30,286			(30,286)		30
31	Building Improvement Booked					11,022			(11,022)		31
32											32
33	2015-Home Office Allocation-Building Improvements				7,581			182	182		33
34	2015-Home Office Allocation-Land Improvements				708			45	45		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 Farmer City Rehab & Hlth Cr # 0050922 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)		$ 1,004,005	$ 41,308		$ 40,321	$ (988)	$ 171,186	70

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

Facility Name & ID Number Farmer City Rehab & Hlth Cr # 0050922 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	$ 65,456	$ 8,683	$ 6,546	$ (2,137)	5-10 yrs.	$ 33,928	71
72	Current Year Purchases	4,139	197	207	10	10 yrs.	207	72
73	Fully Depreciated Assets	151,000	21,571		(21,571)		151,000	73
74	Home Office Allocation			6,459	6,459			74
75	TOTALS	$ 220,595	$ 30,451	$ 13,212	$ (17,239)		$ 185,135	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	2012 Van	2012	$ 18,742	$ 3,748	$ 3,748	$	5 yrs.	$ 13,118	76
77										77
78										78
79										79
80	TOTALS			$ 18,742	$ 3,748	$ 3,748	$		$ 13,118	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)	$ 1,344,342	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 75,507	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 57,281	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (18,227)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 369,439	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

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? [X] YES [ ] NO
16. Rental Amount for movable equipment: $ 4,634 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	2010 Ford Van	$ 685.00	$ 8,220	17
18					18
19					19
20					20
21	TOTAL		$ 685.00	$ 8,220	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.

Farmer City Rehab & Hlth Cr
0050922
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	$	1,538
Dishwasher		711
Copier		1,875
Home Office Allocation		510
		4,634

Facility Name & ID Number Farmer City Rehab & Hlth Cr # 0050922 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 Farmer City Rehab & Hlth Cr # 0050922 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	$	7,365	$ 110,481	$	7,365	$ 110,481	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		402	6,029		402	6,029	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(1), 10A(3)	1801 hrs	27,707	5,917	88,762		7,718	116,469	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				34,046		34,046	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs		2	81		2	81	11
12	Other (specify): Therapy Consultant									12
13	Other (specify):									13
14	TOTAL			$ 27,707	13,686	$ 205,353	$ 34,046	15,487	$ 267,106	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 **Farmer City Rehab & Hlth Cr** **# 0050922** **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	$ 78,259	$ 78,459	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 151,726)	235,905	235,905	3
4	Supply Inventory (priced at Cost)	7,857	7,857	4
5	Short-Term Investments			5
6	Prepaid Insurance	18,257	19,731	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	4,139	4,139	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 344,417	$ 346,091	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		101,000	13
14	Buildings, at Historical Cost		764,699	14
15	Leasehold Improvements, at Historical Cost	88,723	239,306	15
16	Equipment, at Historical Cost	84,198	239,337	16
17	Accumulated Depreciation (book methods)	(98,527)	(369,439)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		18,042	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(4,718)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Real Estate Entity Reserves		179,377	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 74,394	$ 1,167,604	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 418,811	$ 1,513,695	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 381,869	$ 381,869	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	70,826	70,826	30
31	Accrued Taxes Payable (excluding real estate taxes)	115,176	115,176	31
32	Accrued Real Estate Taxes(Sch.IX-B)		26,292	32
33	Accrued Interest Payable		4,320	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	416	416	36
37	Accrued Management Fees	864,159	864,159	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,432,446	$ 1,463,058	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		909,410	40
41	Bonds Payable			41
42	Deferred Compensation	1,293	1,293	42
	Other Long-Term Liabilities(specify):			
43	Intercompany Loans	(1,828,100)	(1,819,594)	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ (1,826,807)	$ (908,891)	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ (394,361)	$ 554,167	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 813,172	$ 959,528	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 418,811	$ 1,513,695	48

***(See instructions.)**

Facility Name & ID Number **Farmer City Rehab & Hlth Cr** **#** **0050922** **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**	$ 561,521	1
2	Restatements (describe):		2
3	**Prior Period Adjustment Made After Cost Report Was Filed**	2,341	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 563,862	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	437,029	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	(187,719)	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)**	$ 249,310	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)**	$ 813,172	24 *

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

Facility Name & ID Number Farmer City Rehab & Hlth Cr # 0050922 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	$ 2,609,606	1
2	Discounts and Allowances for all Levels	(165,607)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,443,999	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	413,474	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 413,474	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	3,180	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	63,172	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	3,657	20
21	Other Medical Services	9,239	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 79,248	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	666	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 666	26
	E. Other Revenue (specify):******		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Transportation Revenue	4,708	28
28a	Miscellaneous Revenue	1,674	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 6,382	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,943,769	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	439,044	31
32	Health Care	1,107,098	32
33	General Administration	526,137	33
	B. Capital Expense		
34	Ownership	224,450	34
	C. Ancillary Expense		
35	Special Cost Centers	84,951	35
36	Provider Participation Fee	125,060	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,506,740	40
41	**Income before Income Taxes (line 30 minus line 40)****	437,029	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 437,029	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 947,799	44
45	Private Pay - Net Inpatient Revenue	1,095,937	45
46	Medicare - Net Inpatient Revenue	342,132	46
47	Other-(specify) Insurance Net Inpatient Revenue	58,304	47
48	Other-(specify) Charity Therapy Allowance	(173)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,443,999	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 Farmer City Rehab & Hlth Cr # 0050922 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	$ 68,941	$ 33.14	1
2	Assistant Director of Nursing	1,473	1,473	32,328	21.95	2
3	Registered Nurses	4,929	5,032	119,195	23.69	3
4	Licensed Practical Nurses	7,187	7,298	154,101	21.12	4
5	CNAs & Orderlies	27,562	28,122	308,993	10.99	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,801	1,935	27,707	14.32	8
9	Activity Director	2,080	2,080	26,054	12.53	9
10	Activity Assistants	1,754	1,754	17,648	10.06	10
11	Social Service Workers	2,080	2,080	26,890	12.93	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	41,960	20.17	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,412	9,754	94,397	9.68	15
16	Dishwashers					16
17	Maintenance Workers	1,971	2,039	29,663	14.55	17
18	Housekeepers	4,650	4,662	43,831	9.40	18
19	Laundry	2,703	2,858	27,834	9.74	19
20	Administrator	2,340	2,340	91,372	39.05	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,125	2,157	48,739	22.60	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,367	1,387	31,100	22.42	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) See PG20A	1,931	2,111	21,242	10.06	33
34	TOTAL (lines 1 - 33)	79,525	81,242	$ 1,211,995 *	$ 14.92	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	6,000	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,703	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	2	81	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)	2	$ 9,784		49

C. CONTRACT NURSES

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

Farmer City Rehab & Hlth Cr
0050922
Period Beginning **1/1/2015**
Period End **12/31/2015**

Schedule 20A

XVIII. Staffing and Salary Costs

		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Restorative Salaries		321	321	3,902	12.16
Transportation		1,610	1,790	17,340	9.69
	TOTAL	1,931	2,111	21,242	

Facility Name & ID Number: Farmer City Rehab & Hlth Cr # 0050922 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %		Amount
Mary Kay Hirsbrunner	Administrator	0	$	85,829
Karen Jones	Administrator	0		5,543
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$	91,372

B. Administrative - Other

Description		Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$	314,100
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$	314,100

C. Professional Services

Vendor/Payee	Type		Amount
Mediacom	Computer Services	$	1,631
Ginoli & Co.	Accounting Fees		5,850
Honkamp Kruger & Co.	Accounting Fees		886
E-Health Data Solutions	Computer Services		4,421
Hinshaw and Culbertson	Legal Fees		15,309
Harriet Belt	Legal Settlement		2,000
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$	30,097

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance	$	28,458
Unemployment Compensation Insurance		10,905
FICA Taxes		80,950
Employee Health Insurance		(15,180)
Employee Meals		
Illinois Municipal Retirement Fund (IMRF)*		
Employee Relations		663
Employee Retirement		425
Home Office Allocation		25,174
TOTAL (agree to Schedule V, line 22, col.8)	$	131,395

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	$	
Advertising: Employee Recruitment		
Health Care Worker Background Check (Indicate # of checks performed 65)		826
Miscellaneous Licenses & Permits		1,208
Miscellaneous Dues & Subscriptions		895
Home Office Allocation		151
Less: Public Relations Expense	(	)
Non-allowable advertising	(	)
Yellow page advertising	(	)
TOTAL (agree to Sch. V, line 20, col. 8)	$	3,080

G. Schedule of Travel and Seminar**

Description		Amount
Out-of-State Travel	$	
In-State Travel		
Seminar Expense		
Home Office Allocation		59
Entertainment Expense	(	)
TOTAL (agree to Sch. V, line 24, col. 8)	$	59

**See instructions.

Farmer City Rehab & Hlth Cr
0050922

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)		30,097
Home Office Allocation		
Denton's US LLP	Legal	84
Applegate and Thorne	Legal	13
Miller Hall and Triggs	Legal	13
Healthcare Resources International	Legal	69
Lexis Nexis	Legal	5
GoffWilson	Legal	578
CliftonLarson Allen	Accountants	893
Ginoli & Co.	Accountants	529
Miscellaneous	Computer Services	61
CCH	Computer Services	10
PTC Select	Computer Services	14
Advanced Answers on Demand	Computer Services	1849
Stratus Networks	Computer Services	336
Kemper Technology	Computer Services	495
AT&T	Computer Services	4
Ability Network	Computer Services	476
CIAN	Computer Services	335
Comcast	Computer Services	13
Emdeon	Computer Services	28
Charter Communications	Computer Services	23
Allscripts	Computer Services	17
Allpayer Exchange	Computer Services	11
E-Health Technologies	Computer Services	7
Macquarie Technology Services	Computer Services	11
Optimizer	Other Prof Fees	32

D.J. Howard Appraisers	Other Prof Fees	29
Key Corporate Services	Other Prof Fees	98
Consolidated Land Surveying	Other Prof Fees	62
Alan Litwiller	Other Prof Fees	13
Total (agree to Schedule V, line 19, column 8)		36,205

Mason Point
0010249

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

Schedule 21A

XIX. SUPPORT SCHEDULE
Legal Fees

Home Office Allocation-PHC & PHCM		
Denton's US LLP	Legal	84
Applegate and Thorne	Legal	13
Miller Hall and Triggs	Legal	13
Healthcare Resources International	Legal	69
Lexis Nexis	Legal	5
GoffWilson	Legal	578
Direct Facility Invoices		
Harriet Belt-Settlement	10/5/2015	2,000
SmithAmundsen LLC-Harriet Belt Case	10/5/2015	6,301
SmithAmundsen LLC-Harriet Belt Case	11/6/2015	1,111
Rowdy Meeks Legal Group LLC-Harriet Belt	12/1/2015	7,500
SmithAmundsen LLC-Harriet Belt Case	12/2/2015	398
Total Legal Fees (agree to Schedule V, line 19, column 8)		18,071

Facility Name & ID Number Farmer City Rehab & Hlth Cr # 0050922 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		$		$	$	$	$	$	$	$	$	$

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA-$795**

(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. $ **23,489** 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. $ **125,060**
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. $ **3,180**

(16) Travel and Transportation

a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents? **Yes** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **4,708**

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. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.