FOR BHF USE

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

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

I. IDPH License ID Number: 0053124

Facility Name: Decatur Rehab & Hlth Care Ct

Address: 136 S Dipper Lane (Number) Decatur (City) 62522 (Zip Code)

County: Macon

Telephone Number: (217) 428-7767 **Fax #** (217) 428-2555

HFS ID Number:

Date of Initial License for Current Owners:

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) 673-3009
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 1/1/2016 to 12/31/2016 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 Decatur Rehab & Hlth Care Ct # 0053124 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	58	Intermediate (ICF)	58	21,170	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	58	TOTALS	58	21,170	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	12,273	1,516	746	14,535	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,273	1,516	746	14,535	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.66%

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 [X] NO [ ]

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

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

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number Decatur Rehab & Hlth Care Ct # 0053124 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	126,639	7,516		134,155		134,155	2,986	137,141			1
2	Food Purchase		92,175		92,175		92,175	(1,275)	90,900			2
3	Housekeeping	125,576	17,308		142,884		142,884	52	142,936			3
4	Laundry	9,766	8,804		18,570		18,570		18,570			4
5	Heat and Other Utilities			46,117	46,117		46,117	174	46,291			5
6	Maintenance	37,442	9,795	20,203	67,440		67,440	1,630	69,070			6
7	Other (specify):* Home Office Ben. Allocation											7
8	TOTAL General Services	299,423	135,598	66,320	501,341		501,341	3,567	504,908			8
	B. Health Care and Programs											
9	Medical Director			15,900	15,900		15,900		15,900			9
10	Nursing and Medical Records	677,396	57,193	16,349	750,938		750,938	(12)	750,926			10
10a	Therapy		105		105		105		105			10a
11	Activities	25,965	697	1,952	28,614		28,614	(3,055)	25,559			11
12	Social Services	31,208			31,208		31,208		31,208			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Office Ben. Allocation											15
16	TOTAL Health Care and Programs	734,569	57,995	34,201	826,765		826,765	(3,067)	823,698			16
	C. General Administration											
17	Administrative			182,700	182,700		182,700	(114,700)	68,000			17
18	Directors Fees											18
19	Professional Services			5,618	5,618		5,618	19,323	24,941			19
20	Dues, Fees, Subscriptions & Promotions			2,284	2,284		2,284	318	2,602			20
21	Clerical & General Office Expenses	32,752	2,507	32,859	68,118		68,118	34,734	102,852			21
22	Employee Benefits & Payroll Taxes			128,978	128,978		128,978	19,462	148,440			22
23	Inservice Training & Education			150	150		150	67	217			23
24	Travel and Seminar							32	32			24
25	Other Admin. Staff Transportation			2,200	2,200		2,200	2,738	4,938			25
26	Insurance-Prop.Liab.Malpractice			18,983	18,983		18,983	386	19,369			26
27	Other (specify):* Home Office Ben. Allocation											27
28	TOTAL General Administration	32,752	2,507	373,772	409,031		409,031	(37,640)	371,391			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,066,744	196,100	474,293	1,737,137		1,737,137	(37,140)	1,699,997			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 Decatur Rehab & Hlth Care Ct #0053124 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			21,526	21,526		21,526	9,598	31,124			30
31	Amortization of Pre-Op. & Org.							20,526	20,526			31
32	Interest							30,979	30,979			32
33	Real Estate Taxes			26,066	26,066		26,066	177	26,243			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			11,702	11,702		11,702	626	12,328			35
36	Other (specify):*											36
37	**TOTAL Ownership**			59,294	59,294		59,294	61,906	121,200			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		17,542		17,542		17,542		17,542			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			120,015	120,015		120,015		120,015			42
43	Other (specify):*		150	35,831	35,981		35,981	(35,981)				43
44	**TOTAL Special Cost Centers**		17,692	155,846	173,538		173,538	(35,981)	137,557			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,066,744	213,792	689,433	1,969,969		1,969,969	(11,215)	1,958,754			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 Decatur Rehab & Hlth Care Ct # 0053124 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,329)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,825)	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	1,896	30		9
10	Interest and Other Investment Income	(5)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(116)	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	(5,790)	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	(25,200)	43		24
25	Fund Raising, Advertising and Promotional	(1,330)	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	(3,947)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (38,646)		$	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)	27,431	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 27,431		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (11,215)		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.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Decatur Rehab & Hlth Care Ct

ID# 0053124

Report Period Beginning: 1/1/2016

Ending: 12/31/2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Offset Transportation Revenue	$ (3,055)	11	1
2	Disallowed Special Events	30	43	2
3	Offset Miscellaneous Office Supplies Revenue	(72)	21	3
4	Labs Part A	(750)	43	4
5	Offset Misc. Nursing Supplies Revenue	(100)	10	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
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**	(3,947)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Decatur Rehab & Hlth Care Ct # 0053124 **Report Period Beginning:** 1/1/2016 **Ending:** 12/31/2016

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	2,986	0	0	0	0	0	0	0	0	0	2,986	1
2	Food Purchase	(1,329)	54	0	0	0	0	0	0	0	0	0	(1,275)	2
3	Housekeeping	0	52	0	0	0	0	0	0	0	0	0	52	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	174	0	0	0	0	0	0	0	0	0	174	5
6	Maintenance	0	1,630	0	0	0	0	0	0	0	0	0	1,630	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,329)	4,896	0	0	0	0	0	0	0	0	0	3,567	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(100)	88	0	0	0	0	0	0	0	0	0	(12)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(3,055)	0	0	0	0	0	0	0	0	0	0	(3,055)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(3,155)	88	0	0	0	0	0	0	0	0	0	(3,067)	16
	C. General Administration													
17	Administrative	0	(114,700)	0	0	0	0	0	0	0	0	0	(114,700)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	7,603	0	11,720	0	0	0	0	0	0	0	19,323	19
20	Fees, Subscriptions & Promotions	0	0	318	0	0	0	0	0	0	0	0	318	20
21	Clerical & General Office Expenses	(72)	0	34,806	0	0	0	0	0	0	0	0	34,734	21
22	Employee Benefits & Payroll Taxes	0	0	19,462	0	0	0	0	0	0	0	0	19,462	22
23	Inservice Training & Education	0	0	67	0	0	0	0	0	0	0	0	67	23
24	Travel and Seminar	0	0	32	0	0	0	0	0	0	0	0	32	24
25	Other Admin. Staff Transportation	0	0	2,738	0	0	0	0	0	0	0	0	2,738	25
26	Insurance-Prop.Liab.Malpractice	0	0	386	0	0	0	0	0	0	0	0	386	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(72)	(107,097)	57,809	11,720	0	0	0	0	0	0	0	(37,640)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(4,556)	(102,113)	57,809	11,720	0	0	0	0	0	0	0	(37,140)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Decatur Rehab & Hlth Care Ct # 0053124 **Report Period Beginning:** 1/1/2016 **Ending:** 12/31/2016

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	1,896	0	7,702	0	0	0	0	0	0	0	0	9,598	30
31	Amortization of Pre-Op. & Org.	0	0	0	20,526	0	0	0	0	0	0	0	20,526	31
32	Interest	(5)	0	226	30,758	0	0	0	0	0	0	0	30,979	32
33	Real Estate Taxes	0	0	177	0	0	0	0	0	0	0	0	177	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	626	0	0	0	0	0	0	0	0	626	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	1,891	0	8,731	51,284	0	0	0	0	0	0	0	61,906	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(35,981)	0	0	0	0	0	0	0	0	0	0	(35,981)	43
44	**TOTAL Special Cost Centers**	(35,981)	0	0	0	0	0	0	0	0	0	0	(35,981)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(38,646)	(102,113)	66,540	63,004	0	0	0	0	0	0	0	(11,215)	45

Facility Name & ID Number Decatur Rehab & Hlth Care Ct # 0053124 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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 Management, Inc.	100.00%	$ 2,986	$ 2,986	1
2	V	2	Food		Petersen Health Care Management, Inc.	100.00%	54	54	2
3	V	3	Housekeeping		Petersen Health Care Management, Inc.	100.00%	52	52	3
4	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	174	174	4
5	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	1,630	1,630	5
6	V	7	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		6
7	V	9	Medical Director		Petersen Health Care Management, Inc.	100.00%	0		7
8	V	10	Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	88	88	8
9	V	10A	Therapy		Petersen Health Care Management, Inc.	100.00%	0		9
10	V	15	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		10
11	V	17	Administrative	182,700	Petersen Health Care Management, Inc.	100.00%	68,000	(114,700)	11
12	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	7,603	7,603	12
13	V								13
14	Total			$ 182,700			$ 80,587	$ * (102,113)	14

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

Facility Name & ID Number Decatur Rehab & Hlth Care Ct # 0053124 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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 Management, Inc.	100.00%	$ 318	$ 318	15
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	34,806	34,806	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	19,462	19,462	17
18	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	67	67	18
19	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	32	32	19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	2,738	2,738	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	386	386	21
22	V	27	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		22
23	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	7,702	7,702	23
24	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	226	226	24
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	177	177	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	626	626	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			$			$ 66,540	$ * 66,540	39

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

Facility Name & ID Number Decatur Rehab & Hlth Care Ct # 0053124 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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%	11,720	11,720	25
26	V	20	Dues, Fees, Subs & Promotions		Petersen Health Wellness, LLC	100.00%	0		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%	0		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%	20,526	20,526	34
35	V	32	Interest		Petersen Health Wellness, LLC	100.00%	30,758	30,758	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			$			$ 63,004	$ * 63,004	39

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

Facility Name & ID Number Decatur Rehab & Hlth Care Ct # 0053124 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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 Management	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Busin	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 X	Peoria	Lessor	13
14			Decatur Rehab & Health Care Center	Decatur	Midwest Health Opera	Peoria	Mgmt/Bookkeeping	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Health Prope	Peoria	Mgmt/Bookkeeping	15
16			Eastview Terrace	Sullivan	Petersen Roseville, LL	Roseville	Lessor	16
17			El Paso Health Care Center	El Paso	Petersen Health Juncti	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Petersen Health Qualit	Peoria	Mgmt/Bookkeeping	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Health and W	Peoria	Mgmt/Bookkeeping	19
20			Flanagan Rehab & Health Care Center	Flanagan	Petersen 24, LLC	Peoria	Hospitality	20
21			Flora Gardens Care Center	Flora				21
22			Flora Health Care Center	Flora				22
23			Fondulac Rehab & Health Care Center	East Peoria				23
24			Havana Health Care Center	Havana				24
25			Illini Heritage Rehab & Health Care	Champaign				25
26			Jonesboro Rehab & Health Care Center	Jonesboro				26
27			Kewanee Care Home	Kewanee				27
28			LaHarpe Davier Health Care Center	LaHarpe				28
29			Lebanon Care Center	Lebanon				29
30			Marigold Rehab & Health Care Center	Galesburg				30

Facility Name & ID Number Decatur Rehab & Hlth Care Ct # 0053124 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

VII. RELATED PARTIES

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

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

Facility Name & ID Number Decatur Rehab & Hlth Care Ct # 0053124 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

VII. RELATED PARTIES

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

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

Facility Name & ID Number Decatur Rehab & Hlth Care Ct # 0053124 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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			Courtyard Estates of Farmington	Farmington				4
5			Courtyard Estates of Knoxville	Knoxville				5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Decatur Rehab & Hlth Care Ct # 0053124 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Decatur Rehab & Hlth Care Ct # 0053124 Report Period Beginning: 1/1/2016 Ending: 2/31/2016

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	1,521,544	75	$ 312,540	$ 357,910	14,535	$ 2,986	1
2	2	Food	Resident Days	1,521,544	75	5,673	0	14,535	54	2
3	3	Housekeeping	Resident Days	1,521,544	75	5,456	2,897	14,535	52	3
4	5	Utilities	Resident Days	1,521,544	75	18,209	0	14,535	174	4
5	6	Maintenance	Resident Days	1,521,544	75	170,632	137,057	14,535	1,630	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,521,544	75	0	0	14,535	0	6
7	9	Medical Director	Resident Days	1,521,544	75	0	0	14,535	0	7
8	10	Nursing and Medical Records	Resident Days	1,521,544	75	9,261	1,782,521	14,535	88	8
9	10A	Therapy	Resident Days	1,521,544	75	0	0	14,535	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,521,544	75	0	0	14,535	0	10
11	17	Administrative	Resident Days	1,521,544	75	4,899,467	5,473,961	14,535	68,000	11
12	19	Professional Services	Resident Days	1,521,544	75	795,918	0	14,535	7,603	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,521,544	75	33,278	0	14,535	318	13
14	21	Clerical and General Office	Resident Days	1,521,544	75	3,643,535	3,756,135	14,535	34,806	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,521,544	75	2,037,314	0	14,535	19,462	15
16	23	Inservice Training & Education	Resident Days	1,521,544	75	6,986	0	14,535	67	16
17	24	Travel and Seminar	Resident Days	1,521,544	75	3,389	0	14,535	32	17
18	25	Other Admin. Staff Transport.	Resident Days	1,521,544	75	286,637	0	14,535	2,738	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,521,544	75	40,378	0	14,535	386	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,521,544	75	0	0	14,535	0	20
21	30	Depreciation	Resident Days	1,521,544	75	806,271	0	14,535	7,702	21
22	32	Interest	Resident Days	1,521,544	75	23,686	0	14,535	226	22
23	33	Real Estate Taxes	Resident Days	1,521,544	75	18,560	0	14,535	177	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,521,544	75	65,550	0	14,535	626	24
25	TOTALS					$ 13,182,740	$ 11,510,481		$ 147,127	25

Facility Name & ID Number Decatur Rehab & Hlth Care Ct # 0053124 Report Period Beginning: 1/1/2016 Ending: 2/31/2016

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	94,948	7	$	$	14,535	$	1
2	2	Food	Resident Days	94,948	7			14,535		2
3	3	Housekeeping	Resident Days	94,948	7			14,535		3
4	4	Laundry	Resident Days	94,948	7			14,535		4
5	5	Utilities	Resident Days	94,948	7			14,535		5
6	6	Maintenance	Resident Days	94,948	7			14,535		6
7	7	Mgmt. Allocation of Benefits	Resident Days	94,948	7			14,535		7
8	10	Nursing and Medical Records	Resident Days	94,948	7			14,535		8
9	15	Mgmt. Allocation of Benefits	Resident Days	94,948	7			14,535		9
10	17	Administrative	Resident Days	94,948	7			14,535		10
11	19	Professional Services	Resident Days	94,948	7	77,776		14,535	11,720	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	94,948	7			14,535		12
13	21	Clerical and General Office	Resident Days	94,948	7			14,535		13
14	22	Employee Benefits & Payroll	Resident Days	94,948	7			14,535		14
15	23	Inservice Training & Education	Resident Days	94,948	7			14,535		15
16	24	Travel and Seminar	Resident Days	94,948	7			14,535		16
17	25	Other Admin. Staff Transport.	Resident Days	94,948	7			14,535		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	94,948	7			14,535		18
19	30	Depreciation	Resident Days	94,948	7			14,535		19
20	31	Amortization	Resident Days	94,948	7	120,699		14,535	20,526	20
21	32	Interest	Resident Days	94,948	7	152,300		14,535	30,758	21
22	33	Real Estate Taxes	Resident Days	94,948	7			14,535		22
23	34	Rent-Facility and Grounds	Resident Days	94,948	7			14,535		23
24	35	Rent-Equipment & Vehicles	Resident Days	94,948	7			14,535		24
25	TOTALS					$ 350,775	$		$ 63,004	25

Facility Name & ID Number Decatur Rehab & Hlth Care Ct # 0053124 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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											$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10								Interest Income Offset			(5)	10
11								Home Office Allocation-PHW			30,758	11
12								Home Office Allocation-PHCM			226	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 30,979	14
15	TOTALS (line 9+line14)						$	$			$ 30,979	15

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

*** 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 Decatur Rehab & Hlth Care Ct # 0053124 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	23,220	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.)	$	24,278	2
3. Under or (over) accrual (line 2 minus line 1).	$	1,058	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)	$	25,008	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** 177			
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.	$	26,243	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	23,400	8
	2012	23,436	9
	2013	22,939	10
	2014	22,544	11
	2015	24,278	12

Accrual based on prior year tax bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Decatur Rehab & Hlth Care Ct COUNTY Macon

FACILITY IDPH LICENSE NUMBER 0053124

CONTACT PERSON REGARDING THIS REPORT MIKE KOCHER

TELEPHONE (309)689-5850 FAX #: (309)691-8622

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-12-17-254-003	Long-Term Care Facility	$ 23,044.54	$ 23,044.54
2.	04-12-17-254-004	Long-Term Care Facility	$ 1,233.10	$ 1,233.10
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 24,277.64	$ 24,277.64

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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 Decatur Rehab & Hlth Care Ct # 0053124 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

X. BUILDING AND GENERAL INFORMATION:

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

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

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

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

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

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

N/A

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

1. Total Amount Incurred: 95,556 2. Number of Years Over Which it is Being Amortized: 20

3. Current Period Amortization: 20,526 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	43,560	2005	$ 37,500	1
2					2
3	TOTALS	43,560		$ 37,500	3

Facility Name & ID Number Decatur Rehab & Hlth Care Ct # 0053124 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	58		2005	1970	$ 275,500	$	25	$ 11,020	$ 11,020	$ 126,730	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Original Land Improvements			2005	10,000		15	667	667	7,670	9
10	Sidewalks			2006	2,311		15	154	154	1,617	10
11	Remodel Nurses Station			2007	6,718		15	448	448	4,256	11
12	Water Heater-100 Gallon			2008	5,604		5			5,604	12
13	Painting-Exterior			2009	4,908		15	328	328	2,696	13
14	Sprinkler System Installation			2009	11,774		15	785	785	5,887	14
15	Windows Installation-(41)			2009	11,234		15	749	749	5,617	15
16	Dry Pendant Installation			2010	6,270		15	418	418	2,717	16
17	Sidewalk Replacement			2011	2,850		15	190	190	1,045	17
18	Roofing-Flat Section of Building			2013	10,400		15	694	694	2,429	18
19	Parking Lot-Asphalt			2013	23,468		25	938	938	3,283	19
20	Air Handler			2015	2,905		15	194	194	291	20
21	Parking Lot Repair			2016	4,300		7	307	307	307	21
22	Water Heater-100 Gallon			2016	4,054		7	290	290	290	22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30	Land Improvements Booked					1,011			(1,011)		30
31	Building Booked					11,069			(11,069)		31
32	Building Improvement Booked					5,231			(5,231)		32
33											33
34	2016-Home Office Allocation-Building Improvements				6,417			154	154		34
35	2016-Home Office Allocation-Land Improvements				590			38	38		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 Decatur Rehab & Hlth Care Ct # 0053124 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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)		$ 389,303	$ 17,311		$ 17,374	$ 63	$ 170,439	70

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

Facility Name & ID Number Decatur Rehab & Hlth Care Ct # 0053124 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	$ 55,763	$ 3,116	$ 4,942	$ 1,826	5-10 yrs.	$ 38,546	71
72	Current Year Purchases	18,172	1,099	1,298	199	7 yrs.	1,298	72
73	Fully Depreciated Assets	62,280					62,280	73
74	Home Office Allocation			7,510	7,510			74
75	TOTALS	$ 136,215	$ 4,215	$ 13,750	$ 9,535		$ 102,124	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)	$ 563,018	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 21,526	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 31,124	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 9,598	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 272,563	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Vacant Land	$ 75,000	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 75,000	$	$	91

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Decatur Rehab & Hlth Care Ct # 0053124 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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.	/2017	$
13.	/2018	$
14.	/2019	$

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

15. Is Movable equipment rental included in building rental? ☒ YES ☐ NO

16. Rental Amount for movable equipment: $ 7,010 Description: See Attached Schedule 14A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2012 Ford E250	$ 347.24	$ 5,318	17
18					18
19					19
20					20
21	TOTAL		$ 347.24	$ 5,318	21

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

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

Decatur Rehab & Hlth Care Ct
0053124
Period Beginning **1/1/2016**
Period End **12/31/2016**

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	$	1,946
Dishwasher		710
Copier		3,728
Home Office Allocation		626
		7,010

Facility Name & ID Number Decatur Rehab & Hlth Care Ct # 0053124 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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 Decatur Rehab & Hlth Care Ct # 0053124 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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(2)	hrs	$		$	$ 105		$ 105	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				17,542		17,542	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			$		$	$ 17,647		$ 17,647	14

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

Facility Name & ID Number Decatur Rehab & Hlth Care Ct # 0053124 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2016 (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	$ (199,325)	$ (199,325)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 72,184)	642,373	642,373	3
4	Supply Inventory (priced at Cost)	7,380	7,380	4
5	Short-Term Investments			5
6	Prepaid Insurance	16,921	16,921	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Security Deposit & PPD Lease	2,551	2,551	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 469,900	$ 469,900	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	127,661	37,500	13
14	Buildings, at Historical Cost	275,500	281,917	14
15	Leasehold Improvements, at Historical Cost	91,635	107,386	15
16	Equipment, at Historical Cost	136,215	136,215	16
17	Accumulated Depreciation (book methods)	(272,072)	(272,563)	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): Vacant Land		75,000	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 358,939	$ 365,455	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 828,839	$ 835,355	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 169,510	$ 169,510	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	54,963	54,963	30
31	Accrued Taxes Payable (excluding real estate taxes)	24,342	24,342	31
32	Accrued Real Estate Taxes(Sch.IX-B)	25,008	25,008	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	65,985	65,985	36
37	Accrued Management Fees	460,770	460,770	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 800,578	$ 800,578	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	59	59	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 59	$ 59	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 800,637	$ 800,637	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 28,202	$ 34,718	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 828,839	$ 835,355	48

***(See instructions.)**

Facility Name & ID Number Decatur Rehab & Hlth Care Ct # 0053124 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (3,784)	1
2	Restatements (describe):		2
3	**Prior Period Adjustments Made After Cost Report Was Filed**	(16,000)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (19,784)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	47,986	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)**	$ 47,986	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)**	$ 28,202	24 *

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

Facility Name & ID Number Decatur Rehab & Hlth Care Ct # 0053124 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	$ 1,988,792	1
2	Discounts and Allowances for all Levels	2,013	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,990,805	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	5,285	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 5,285	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,329	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	16,347	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	511	20
21	Other Medical Services	446	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 18,633	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 5	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Transportation Revenue	3,055	28
28a	Miscellaneous Revenue	172	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,227	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,017,955	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	501,341	31
32	Health Care	826,765	32
33	General Administration	409,031	33
	B. Capital Expense		
34	Ownership	59,294	34
	C. Ancillary Expense		
35	Special Cost Centers	53,523	35
36	Provider Participation Fee	120,015	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,969,969	40
41	**Income before Income Taxes (line 30 minus line 40)****	47,986	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 47,986	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,708,462	44
45	Private Pay - Net Inpatient Revenue	178,081	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) Veterans -Net Patient Revenue	107,165	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 1,993,708	49

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

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

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

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

Facility Name & ID Number Decatur Rehab & Hlth Care Ct # 0053124 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,088	2,088	$ 70,316	$ 33.68	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,759	1,782	40,255	22.59	3
4	Licensed Practical Nurses	12,102	12,220	221,923	18.16	4
5	CNAs & Orderlies	20,602	21,496	281,605	13.10	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,062	2,062	24,853	12.05	9
10	Activity Assistants					10
11	Social Service Workers	1,916	2,061	31,208	15.14	11
12	Dietician					12
13	Food Service Supervisor	2,082	2,082	25,848	12.41	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,211	11,212	100,791	8.99	15
16	Dishwashers					16
17	Maintenance Workers	2,623	2,702	37,442	13.86	17
18	Housekeepers	12,463	13,058	125,576	9.62	18
19	Laundry	1,040	1,040	9,766	9.39	19
20	Administrator	2,080	2,080	68,000	32.69	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,116	2,132	32,752	15.36	23
24	Clerical					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 C: CPC	2,485	2,494	63,297	25.38	32
33	Other(specify) Transportation	111	111	1,112	10.02	33
34	TOTAL (lines 1 - 33)	76,740	78,620	$ 1,134,744 *	$ 14.43	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	15,900	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,179	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)		$ 19,079		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	25	$ 1,118	L10, C3	50
51	Licensed Practical Nurses	328	12,026	L10, C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	353	$ 13,144		53

Facility Name & ID Number Decatur Rehab & Hlth Care Ct # 0053124 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Christopher White	Administrator	0	$ 68,000
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 68,000

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 182,700
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 182,700

C. Professional Services

Vendor/Payee	Type	Amount
Comcast Cable	Computer Services	$ 1,258
E-Health Data Solutions	Computer Services	2,221
Honkamp Krueger	Accounting Services	637
Allscript	Computer Services	961
Macon Co Circuit Clerk	Legal Fees	270
Clark Co Circuit Clerk	Legal Fees	121
Gary L. Vits	Legal Fees	150
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 5,618

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 21,047
Unemployment Compensation Insurance	27,259
FICA Taxes	75,097
Employee Health Insurance	3,448
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	2,127
Home Office Allocation	19,462
TOTAL (agree to Schedule V, line 22, col.8)	$ 148,440

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

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 39)	171
Patient Background Checks	
Miscellaneous Licenses & Permits	1,113
Miscellaneous Dues & Subscriptions	1,000
Home Office Allocation	318
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 2,602

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

* Attach copy of IMRF notifications

**See instructions.

Decatur Rehab & Hlth Care Ct
0053124
Period Beginning **1/1/2016**
Period End **12/31/2016**

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		5,618
Home Office Allocation		
Lucie, Scalf, and Bougher	Legal	34
Miscellaneous	Legal	12
Miller Hall and Triggs	Legal	59
Healthcare Resources International	Legal	293
Hunziker Law	Legal	70
Lexis Nexis	Legal	6
Gemino	Legal	5,279
Illinois Secretary of State	Legal	38
Peoria County Recorder	Legal	16
CliftonLarson Allen	Accountants	305
Ginoli & Co.	Accountants	3,095
Miscellaneous	Computer Services	39
Change Healthcare	Computer Services	6
PTC Select	Computer Services	3
Advanced Answers on Demand	Computer Services	2,677
Stratus Networks	Computer Services	272
Kemper Technology	Computer Services	179
AT&T	Computer Services	4
Ability Network	Computer Services	1,141
CIAN	Computer Services	136
Comcast	Computer Services	22
CCH	Computer Services	9
Charter Communications	Computer Services	26
Allscripts	Computer Services	398
ATS	Computer Services	180
Allpayer Exchange	Computer Services	9
Optimizer	Other Prof Fees	27
Ankura	Other Prof Fees	208
David Budde	Other Prof Fees	24
Bruner, Cooper, Zuck	Other Prof Fees	61
Marotta, Gund, Budd, Dzerda	Other Prof Fees	4,660
Professional Software and Services	Other Prof Fees	15
Hughes Valuation Services	Other Prof Fees	19
Alan Litwiller	Other Prof Fees	1
Total (agree to Schedule V, line 19, column 8)		24,941

Facility Name & ID Number Decatur Rehab & Hlth Care Ct # 0053124 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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. **ICHA $1000**

(3) Did the nursing home make political contributions or payments to a politica
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? **7 yrs.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **17,342** 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 fo
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 Departmen
during this cost report period. $ **120,015**
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 tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **0** Has any meal income been offset against
related costs? **Yes** Indicate the amount. $ **1,329**

(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 fo
residents? **Yes** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **3,055**
c. What percent of all travel expense relates to transportation of nurses and patients? **100**
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? **Yes**
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. $ **N/A**

(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. **No**
Attach invoices and a summary of services for all architect and appraisal fees

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Deta	-11,215	equal to	-11,215	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expens	30,979	equal to	30,979	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax	26,243	equal to	26,243	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp	20,526	equal to	20,526	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Cost	31,124	equal to	31,124	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	12,328	equal to	12,328	0	FAILED	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Traini	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to	0	0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Service	105	equal to	105	0	O.K.	Pg16 Z12+Z14..	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- S	17,647	equal to	17,647	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. Ge	501,341	equal to	501,341	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. He	826,765	equal to	826,765	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Ad	409,031	equal to	409,031	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ov	59,294	equal to	59,294	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Sp	53,523	equal to	53,523	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+I	N/A	38to41+43	4
Income Stat. Pr	120,015	equal to	120,015	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	677,396	equal to	677,396	0	O.K.	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aid	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed T	0	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	25,965	equal to	25,965	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Se	31,208	equal to	31,208	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	126,639	equal to	126,639	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenar	37,442	equal to	37,442	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekee	125,576	equal to	125,576	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	9,766	equal to	9,766	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administra	68,000	equal to	68,000	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	32,752	equal to	32,752	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical D	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries A	1,134,744	equal to	1,066,744	68,000	FAILED	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consulta	0	< or = to		#VALUE!	#VALUE!	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Directo	15,900	< or = to	15,900	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & c	16,323	< or = to	16,349	-26	O.K.	Pg20 X14..X16+	B. & C.	i7to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consulta	0	< or = to	1,952	-1,952	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service C	0	< or = to		0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- A	68,000	equal to	68,000	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- A	182,700	equal to	182,700	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- F	5,618	equal to	5,618	0	FAILED	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- E	148,440	equal to	148,440	0	FAILED	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- S	2,602	equal to	2,602	0	FAILED	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- S	32	equal to	32	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Parti	120,015	equal to	120,015	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Emp	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide train	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medica	0	equal to	0	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for r	27,431	equal to	27,431	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4	B.	14	8
Total loan balan	0	equal to	0	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27.	N/A	29+39-41	2
Real estate tax	25,008	equal to	25,008	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	37,500	equal to	37,500	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	389,303	equal to	389,303	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and	136,215	equal to	136,215	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated de	272,563	equal to	272,563	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equ	28,202	equal to	28,202	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (los	47,986	equal to	47,986	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized de	0	equal to		0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	828,839	equal to	828,839	0	O.K.	Pg17:H41	N/A	25	1	Pg17 S41	N/A	48	1

Enter Cost Cen **YOU HAVE CHOSEN THE SUPPORT CALC. THAT IS LINKED TO THE COST REPORT!!!!!** 7/7/2017 09:54:05 AM

HSA Number: 4 Name: **Decatur Rehab & Hlth Care Ct**

Cost report peri From: 1/1/2016 To: 12/31/2016 Base Number: 492

If this is an ICF/DD 16 facility, e N

Licensed bed d 21,170 Occupancy: 14,535 Pct. of occupan 68.66%

ıblic Aid Support Rate: $

Genl Services S	299,423	Col 1, Line 8 ---Audit Adj:	
Genl Admin Sal	32,752	Col 1, Line 28 ---Audit Adj:	
Total Salary W	1,066,744	Col 1, Line 44 ---Audit Adj:	
Employee Bene	148,440	Col 8, Line 22 ---Audit Adj:	
Total General S	504,908	Col 8, Line 8 ---Audit Adj:	
Total General A	371,391	Col 8, Line 28 ---Audit Adj:	

Instructions and Calculation Steps

STEP I Adjust Support Service Costs to Include Correct Amounts of Fringe Benefits and Payroll Taxes.

Fringe benefits and payroll taxes are reported as a lump sum under General Administration expenses on your cost report (Page 3, Column 10, Line 22). You will need to take this amount out of General Administration expenses and calculate the correct portions of this lump sum to be added to your general services and General Administration expenses. This is done by proration.

A. General Services

1 Determine the proportion of general services wages to total wages.

2 Multiply the total lump sum fringe amount by this proportion to get the fringe amount for General Services.

3 Add the proportioned fringe amount to you total general services expenses to get your new total general services cost.

General Services Wages (Column 1, Line 8)	$299,423
Divided by Total Wages (Column 1, Line 44)	$1,066,744
General service wages as percent of total wages	28.0689%
Employee Benefits (Column 10, Line 22)	$148,440
Allocation of Employee Benefits to General Services Costs	$41,665
Plus Total General Services (Column 10, Line 8)	$504,908
New Total General Services Cost	$546,573

B. General Administration

1 Determine the proportion of General Administration wages to total wages.

2 Multiply the total lump sum fringe amount by this proportion to get the fringes amount for General Administration.

3 Add the proportioned fringe amount to your total General Administration expenses.

4 Subtract the total lump sum fringe amount from your General Administration expenses to get your new total General Administration Cost.

General Administration Wages (Column 1, Line 28).	$32,752
Divided by Total Wages (Column 1, Line 45)	$1,066,744
General administration wages as a percent of total wages	3.0703%
Employee Benefits (Column 10, Line 22)	$148,440
Allocation of Employee Benefits to General Admin. Costs	$4,558
Plus Total General Administration (Column 10, Line 28)	$371,391
Minus Total Fringe (Column 10, Line 22)	$148,440
New Total General Administration Cost	$227,509

STEP II Adjust Support Service Costs for Inflation

To calculate the impact of inflation, different inflation fators are used for the General Service and General Administration costs of your cost report. These inflation factors are listed in Table I, Inflation Multipliers. To select the appropriate inflation factors, you need to calculate your base number using the formula outlined below. Once you have calculated your base number, find it in Table I. Select the inflation factors which correspond with your base number and use these in updating your support cost.

A. Base Number Calculation

Convert the beginning and ending dates of your cost reporting period (page 1, Schedule II of your cost report) into numbers and apply the following formula:

Beginning Month + Ending Mon	13	divided by 2 =	6.5
Beginning Day + Ending Day =	32	divided by 60.8 =	0.526315789
Beginning Year + Ending Year -	232	multiplied by 6 =	1392
Sum of the three lines			1399.026316
Subtract from the sum			907.00
Base Number (expressed as a whole number, fraction dropped)			492

B. Select the Appropriate Inflation Multipliers

Refer to Table I, inflation Multipliers, and find the multipliers which correspond with the base number you have calculated.

General Services Multiplier:	1
General Administration Multiplier:	1

C. Apply Inflation Multipliers to Update Cost

1 Multiply New Total General Services Cost (from Step I-A) by the appropriate multiplier from Table I:

New Total General Service Cost (Step I-A)	$546,573	
General Services Multiplier (Step II-B)	1	
Updated General Services Cost		$546,573

2 Multiply New Total General Administration Cost (from Step I-B)by the appropriate multiplier from Table I:

New Total General Service Cost (Step I-B)	$227,509	
General Administration Multiplier (Step II-B)	1	
Updated General Services Cost		$227,509
3 Total Updated Support Costs (1 + 2)		$774,082

STEP III Convert Total Updated Support Costs (C-3) to Per Diem Costs

Use one of the two procedures below to compute per diem costs.

CALCULATED PER DIEM SUPPORT COSTS $47.63

A. If the occupancy (Cost Report, Page 2, Schedule III-C) is equal to or above 93 percent, divide your total updated support costs (Step II, C, 3, above) by the total patient days (Cost Report, Page 2, Schedule III-B, Column 5, Line 14).

Total Support Costs (Step II, C, 3, above)	$774,082
Total Patient Days (Cost Report)	14,535
Support Costs per Diem	$53.26

OR

B. If the occupancy is below 93 percent, calculate 93 percent of the licensed bed days (Cost Report, Page 2, Schedule III-A, Column 4, Line 7). Then subtract the total patient days (Cost Report, Page 2, Schedule III-B, Column 5, Line 14) from the result and calculate one-third of the difference. Then add the one-third difference to the total patient days to obtain your adjusted occupancy. Next divide your total updated Support Costs (Step II, C, 3 above) by your adjusted occupancy.

Licensed Bed Days	21,170
Multiplied by	0.93
	19,688
Minus total Patient Days	14,535
	5,153
One-third of difference	1,718
Plus Total Patient Days	14,535
Adjusted Occupancy	16,253
Total Support Costs (Step II, C, 3, above)	$774,082
Divided by Adjusted Occupany	16253
Support Costs Per Diem	$47.63

STEP IV Calculate Support Rate

The maximum allowable support reimbursement rate is the 75th percentile for your region. The 35th and 75th percentile rates by HSA are listed in Table II, support Rate Percentiles by HSA. Use one of the three procedures below and refer to Table II to calculate your support rate.

A. If your support costs per diem from STEP II is equal to or greater than the 75th percentile for your HSA, then your support rate is the 75th percentile rate listed in Table II.

B. If your support costs per diem from Step III is equal to or greater than the 35th percentile, but less than the 75th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate listed in Table II. Use the following procedure to calculate your rate:

75 Percentile Rate for your HSA	$47.44
Minus Support Costs Per Diem	$47.63
Difference	-$0.19
Multiply the Difference by	0.5
One-Half of the Difference	-$0.10
Plus Support Costs Per Diem	$47.63
Support Rate if costs are between 35th and 75th percentile	47.53

C. If your support cost per diem from Step III is below the 35th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate up to a ceiling. This ceiling is equal to 50 percent of the difference between the 35th and 75th percentiles plus $.05. The ceiling for each HSA is listed in Table II. Use the following procedure to calculate your rate:

75 Percentile Rate for your HSA	$47.44
Minus Support Costs Per Diem	$47.63
Difference	-$0.19
Multiply the Difference by	0.5
One-Half of the Difference	-$0.10
Compare one-half the difference to the profit ceiling for your HSA in Table II and	3.795
Enter the Lower of the Two Amounts	-$0.100
Plus Support Costs Per Diem	$47.63
Support Rate if support costs less than 35th percentile	$47.53

D. YOUR FINAL TOTAL SUPPORT RATE from A, B, or C above **$47.44**

75th Percentile is	$47.44
35th Percentile is	$39.95

Table I
Inflation Multipliers

Base Number	General Services Multiplier	General Administration Multiplier
261	1.1187	1.1531
262	1.1182	1.1530
263	1.1178	1.1528
264	1.1071	1.1376
265	1.1067	1.1375
266	1.1062	1.1373
267	1.0975	1.1249
268	1.0971	1.1248
269	1.0966	1.1246
270	1.0887	1.1134
271	1.0882	1.1132
272	1.0877	1.1130
273	1.0815	1.1043
274	1.0811	1.1042
275	1.0806	1.1040
276	1.0730	1.0932
277	1.0725	1.0931
278	1.0720	1.0929
279	1.0666	1.0853
280	1.0661	1.0851
281	1.0657	1.0850
282	1.0588	1.0753
283	1.0583	1.0751
284	1.0579	1.0750
285	1.0535	1.0690
286	1.0531	1.0689
287	1.0527	1.0687
288	1.0413	1.0524
289	1.0409	1.0522
290	1.0404	1.0521
291	1.0321	1.0403
292	1.0317	1.0402
293	1.0313	1.0400
294	1.0254	1.0318
295	1.0250	1.0317
296	1.0246	1.0315
297	1.0228	1.0294
298	1.0224	1.0293
299	1.0219	1.0291
300	1.0166	1.0218
301	1.0162	1.0216
302	1.0158	1.0215
303	1.0076	1.0098
304	1.0072	1.0097
305	1.0067	1.0095
306	1.0000	1.0000

Table II
SupportRate percentiles by HSA

HSA	75th Percentile	35th Percentile	Below 35th Profit Ceiling
1	48.45	39.86	4.345
2	47.44	39.95	3.795
3	41.84	34.67	3.635
4	47.44	39.95	3.795
5	41.31	34.45	3.645
6	52.64	38.99	6.875
7	52.64	38.99	6.875
8	52.64	38.99	6.875
9	49.92	38.30	5.860
10	48.45	39.86	4.345
11	43.93	35.79	4.120

Table II (For ICF/DD 16 Facilities)
SupportRate percentiles by HSA
Not updated with current figures

HSA	75th Percentile	35th Percentile	Below 35th Profit Ceiling
1	34.86	27.19	3.885
2	33.30	25.97	3.715
3	32.74	25.54	3.650
4	33.30	25.97	3.715
5	30.46	23.75	3.405
6	40.44	31.54	4.500
7	40.44	31.54	4.500
8	40.44	31.54	4.500
9	37.60	29.32	4.190
10	34.86	27.19	3.885
11	32.73	25.52	3.655

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	126,639	7,516	0	134,155	0	134,155	2,986	137,141
2. Food Purchase	0	92,175	0	92,175	0	92,175	-1,275	90,900
3. Housekeeping	125,576	17,308	0	142,884	0	142,884	52	142,936
4. Laundry	9,766	8,804	0	18,570	0	18,570	0	18,570
5. Heat and Other Utilities	0	0	46,117	46,117	0	46,117	174	46,291
6. Maintenance	37,442	9,795	20,203	67,440	0	67,440	1,630	69,070
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	299,423	135,598	66,320	501,341	0	501,341	3,567	504,908
9. Medical Director	0	0	15,900	15,900	0	15,900	0	15,900
10. Nursing & Medical Records	677,396	57,193	16,349	750,938	0	750,938	-12	750,926
10a. Therapy	0	105	0	105	0	105	0	105
11. Activities	25,965	697	1,952	28,614	0	28,614	-3,055	25,559
12. Social Services	31,208	0	0	31,208	0	31,208	0	31,208
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	734,569	57,995	34,201	826,765	0	826,765	-3,067	823,698
17. Administrative	0	0	182,700	182,700	0	182,700	-114,700	68,000
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	5,618	5,618	0	5,618	19,323	24,941
20. Fees, Subscriptions & Promotion	0	0	2,284	2,284	0	2,284	318	2,602
21. Clerical & General Office	32,752	2,507	32,859	68,118	0	68,118	34,734	102,852
22. Employee Benefits & Payroll	0	0	128,978	128,978	0	128,978	19,462	148,440
23. Inservice Training & Education	0	0	150	150	0	150	67	217
24. Travel and Seminar	0	0	0	0	0	0	32	32
25. Other Admin. Staff Trans	0	0	2,200	2,200	0	2,200	2,738	4,938
26. Insurance-Prop.Liab.Malpractice	0	0	18,983	18,983	0	18,983	386	19,369
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	32,752	2,507	373,772	409,031	0	409,031	-37,640	371,391
29. Total General Administrative	1,066,744	196,100	474,293	1,737,137	0	1,737,137	-37,140	#######
30. Depreciation	0	0	21,526	21,526	0	21,526	9,598	31,124
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	20,526	20,526
32. Interest	0	0	0	0	0	0	30,979	30,979
33. Real Estate	0	0	26,066	26,066	0	26,066	177	26,243
34. Rent - Facility & Grounds	0	0	0	0	0	0	0	0
35. Rent - Equipment & Vehicles	0	0	11,702	11,702	0	11,702	626	12,328
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	59,294	59,294	0	59,294	61,906	121,200
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	17,542	0	17,542	0	17,542	0	17,542
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	120,015	120,015	0	120,015	0	120,015
43. Other (specify):*	0	150	35,831	35,981	0	35,981	-35,981	0
44. Total Special Cost Ce	0	17,692	155,846	173,538	0	173,538	-35,981	137,557
45. Grand Total	1,066,744	213,792	689,433	1,969,969	0	1,969,969	-11,215	#######

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	-199,325	-199,325
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	642,373	642,373
4. Supply Inventory	7,380	7,380
5. Short-Term Investments	0	0
6. Prepaid Insurance	16,921	16,921
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	2,551	2,551
10. Total current assets	469,900	469,900
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	127,661	37,500
14. Buildings, at Historical Cost	275,500	281,917
15. Leasehold Improvements, Historical Cost	91,635	107,386
16. Equipment, at Historical Cost	136,215	136,215
17. Accumulated Depreciation (book methods)	-272,072	-272,563
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	75,000
24. Total Long-Term Assets	358,939	365,455
25. Total Assets	828,839	835,355
CURRENT LIABILITIES		
26. Accounts Payable	169,510	169,510
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	54,963	54,963
31. Accrued Taxes Payable	24,342	24,342
32. Accrued Real Estate Taxes	25,008	25,008
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	65,985	65,985
37. Other Current Liabilities (specify):	460,770	460,770
38. Total Current Liabilities	800,578	800,578
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	0
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	59	59
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	59	59
46.Total Liabilities	800,637	800,637
47.Total Equity	28,202	34,718
48.Total Liabilities and Equity	828,839	835,355

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	1,988,792
2. Discounts and Allowances for all Levels	2,013
Subtotal - Inpatient Care	1,990,805
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	5,285
7. Oxygen	0
Subtotal - Anciliary Revenue	5,285
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	1,329
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	16,347
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiologyand X-Ray	511
21. Other Medical Services	446
22. Laundry	0
Subtotal - Other Operating Revenue	18,633
24. Contributions	0
25. Interest and Other Investments Income	5
Subtotal - Non-Operating Revenue	5
27. Other Revenue (specify):	3,055
28. Other Revenue (specify):	172
Subtotal - Other Revenue	3,227
30. Total Revenue	2,017,955
31. General Services	467,123
32. Health Care	760,841
33. General Administration	387,472
34. Ownership	67,835
35. Special Cost Centers	95,346
35. Provider Participation Fee	115,484
37. Other	0
40. Total Expenses	1,894,101
41. Income Before Income Taxes	123,854
42. Income Taxes	0
43. Net Income or Loss for the Year	123,854