

		FOR BHF USE					

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

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

<p><b>I. IDPH License ID Number:</b> <u>0053165</u></p> <p><b>Facility Name:</b> <u>Havana Health Care Center</u></p> <p><b>Address:</b> <u>609 N Harpham St</u> <u>Havana</u> <u>62644</u>  Number City Zip Code</p> <p><b>County:</b> <u>Mason</u></p> <p><b>Telephone Number:</b> <u>(309) 543-6121</u> <b>Fax #</b> <u>(309) 543-1233</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>03/01/01</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Mike Kocher</u> <b>Telephone Number:</b> <u>(309) 673-3009</u>  <b>Email Address:</b> _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2016</u> to <u>12/31/2016</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%"> <tr> <td rowspan="2" style="width:15%; vertical-align: top;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Mark B. Petersen</u> (Date) _____</td> </tr> <tr> <td></td> <td>(Title) <u>Chief Executive Officer</u></td> </tr> <tr> <td rowspan="4" style="vertical-align: top;"><b>Paid Preparer</b></td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> </tr> <tr> <td>(Firm Name &amp; Address) _____</td> </tr> <tr> <td></td> <td>(Telephone) ( ) ( ) Fax # ( ) ( )</td> </tr> </table> <p><b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>  201 S. Grand Avenue East  Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Type or Print Name) <u>Mark B. Petersen</u> (Date) _____		(Title) <u>Chief Executive Officer</u>	<b>Paid Preparer</b>	(Signed) _____	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) _____		(Telephone) ( ) ( ) Fax # ( ) ( )
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																			
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	(Telephone) ( ) ( ) Fax # ( ) ( )																																				

Facility Name & ID Number Havana Health Care Center

# 0053165 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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	20	Skilled (SNF)	20	7,300	1
2		Skilled Pediatric (SNF/PED)			2
3	78	Intermediate (ICF)	78	28,470	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	98	TOTALS	98	35,770	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF		4,284	2,290	6,574	8
9	SNF/PED					9
10	ICF	14,264			14,264	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,264	4,284	2,290	20,838	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 58.26%

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)

Jail Meals

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES  NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES  NO

I. On what date did you start providing long term care at this location?

Date started 3/1/2001

J. Was the facility purchased or leased after January 1, 1978?

YES  Date 3/1/2001 NO

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

YES  NO  If YES, enter number of beds certified 20 and days of care provided 1,685

Medicare Intermediary National Government Services

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

Is your fiscal year identical to your tax year? YES  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 Havana Health Care Center # 0053165 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 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	157,533	25,472		183,005		183,005	4,280	187,285		1
2	Food Purchase		190,482		190,482		190,482	(44,512)	145,970		2
3	Housekeeping	89,664	12,692		102,356		102,356	75	102,431		3
4	Laundry	43,960	8,363		52,323		52,323		52,323		4
5	Heat and Other Utilities			67,027	67,027		67,027	249	67,276		5
6	Maintenance	48,068	6,369	36,502	90,939		90,939	2,337	93,276		6
7	Other (specify):* <u>Home Office Ben. Allocation</u>										7
8	<b>TOTAL General Services</b>	339,225	243,378	103,529	686,132		686,132	(37,571)	648,561		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			19,200	19,200		19,200		19,200		9
10	Nursing and Medical Records	999,070	108,697	12,295	1,120,062		1,120,062	127	1,120,189		10
10a	Therapy			243,412	243,412		243,412		243,412		10a
11	Activities	45,776	274	84	46,134		46,134	(8,231)	37,903		11
12	Social Services	44,050			44,050		44,050		44,050		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Office Ben. Allocation</u>										15
16	<b>TOTAL Health Care and Programs</b>	1,088,896	108,971	274,991	1,472,858		1,472,858	(8,104)	1,464,754		16
	<b>C. General Administration</b>										
17	Administrative			260,400	260,400		260,400	(197,151)	63,249		17
18	Directors Fees										18
19	Professional Services			9,317	9,317		9,317	14,406	23,723		19
20	Dues, Fees, Subscriptions & Promotions			5,781	5,781		5,781	456	6,237		20
21	Clerical & General Office Expenses	35,126	7,432	11,551	54,109		54,109	49,766	103,875		21
22	Employee Benefits & Payroll Taxes			207,608	207,608		207,608	27,902	235,510		22
23	Inservice Training & Education							96	96		23
24	Travel and Seminar							46	46		24
25	Other Admin. Staff Transportation			11,966	11,966		11,966	3,926	15,892		25
26	Insurance-Prop.Liab.Malpractice			31,079	31,079		31,079	553	31,632		26
27	Other (specify):* <u>Home Office Ben. Allocation</u>										27
28	<b>TOTAL General Administration</b>	35,126	7,432	537,702	580,260		580,260	(100,000)	480,260		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,463,247	359,781	916,222	2,739,250		2,739,250	(145,675)	2,593,575		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 Havana Health Care Center

#0053165

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			102,712	102,712		102,712	6,817	109,529			30
31	Amortization of Pre-Op. & Org.							17,334	17,334			31
32	Interest			86,088	86,088		86,088	1,340	87,428			32
33	Real Estate Taxes			77,342	77,342		77,342	254	77,596			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			37,607	37,607		37,607	898	38,505			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			303,749	303,749		303,749	26,643	330,392			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		46,479		46,479		46,479		46,479			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			166,971	166,971		166,971		166,971			42
43	Other (specify):*		1,270	78,007	79,277		79,277	(79,277)				43
44	<b>TOTAL Special Cost Centers</b>		47,749	244,978	292,727		292,727	(79,277)	213,450			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,463,247	407,530	1,464,949	3,335,726		3,335,726	(198,309)	3,137,417			45

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

**VI. ADJUSTMENT DETAIL**

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(10,460)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,460)	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	(4,225)	30		9
10	Interest and Other Investment Income	(522)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(735)	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	(8,268)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(16,000)	43		24
25	Fund Raising, Advertising and Promotional	(1,922)	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	(92,386)	Various		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (136,978)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(61,331)	Various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (61,331)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (198,309)		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY							
48		49		50		51	

Havana Health Care Center

ID# 0053165

Report Period Beginning: 1/1/2016

Ending: 12/31/2016

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (46,316)	43	1
2	X-Rays-Part A	(3,729)	43	2
3	Offset of Office Supplies Income	(133)	21	3
4	Offset of Jail Meals Revenue	(34,130)	2	4
5	Offset of Transportation Revenue	(8,231)	11	5
6	Disallowed Special Events	153	43	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	<b>Total</b>	(92,386)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Havana Health Care Center# 0053165

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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	4,280	0	0	0	0	0	0	0	0	0	4,280	1
2	Food Purchase	(44,590)	78	0	0	0	0	0	0	0	0	0	(44,512)	2
3	Housekeeping	0	75	0	0	0	0	0	0	0	0	0	75	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	249	0	0	0	0	0	0	0	0	0	249	5
6	Maintenance	0	2,337	0	0	0	0	0	0	0	0	0	2,337	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(44,590)</b>	<b>7,019</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(37,571)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	127	0	0	0	0	0	0	0	0	0	127	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(8,231)	0	0	0	0	0	0	0	0	0	0	(8,231)	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	<b>TOTAL Health Care and Programs</b>	<b>(8,231)</b>	<b>127</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(8,104)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(197,151)	0	0	0	0	0	0	0	0	0	(197,151)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	10,900	0	3,506	0	0	0	0	0	0	0	14,406	19
20	Fees, Subscriptions & Promotions	0	0	456	0	0	0	0	0	0	0	0	456	20
21	Clerical & General Office Expenses	(133)	0	49,899	0	0	0	0	0	0	0	0	49,766	21
22	Employee Benefits & Payroll Taxes	0	0	27,902	0	0	0	0	0	0	0	0	27,902	22
23	Inservice Training & Education	0	0	96	0	0	0	0	0	0	0	0	96	23
24	Travel and Seminar	0	0	46	0	0	0	0	0	0	0	0	46	24
25	Other Admin. Staff Transportation	0	0	3,926	0	0	0	0	0	0	0	0	3,926	25
26	Insurance-Prop.Liab.Malpractice	0	0	553	0	0	0	0	0	0	0	0	553	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(133)</b>	<b>(186,251)</b>	<b>82,878</b>	<b>3,506</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(100,000)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(52,954)</b>	<b>(179,105)</b>	<b>82,878</b>	<b>3,506</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(145,675)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Havana Health Care Center# 0053165

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(4,225)	0	11,042	0	0	0	0	0	0	0	0	6,817	30
31	Amortization of Pre-Op. & Org.	0	0	0	17,334	0	0	0	0	0	0	0	17,334	31
32	Interest	(522)	0	324	1,538	0	0	0	0	0	0	0	1,340	32
33	Real Estate Taxes	0	0	254	0	0	0	0	0	0	0	0	254	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	898	0	0	0	0	0	0	0	0	898	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(4,747)</b>	<b>0</b>	<b>12,518</b>	<b>18,872</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>26,643</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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):*	(79,277)	0	0	0	0	0	0	0	0	0	0	(79,277)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(79,277)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(79,277)</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(136,978)</b>	<b>(179,105)</b>	<b>95,396</b>	<b>22,378</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(198,309)</b>	<b>45</b>



**VII. RELATED PARTIES**

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark B. Petersen	100	See PG6-Supp		See PG6-Supp		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	1 Dietary	\$	Petersen Health Care Management, Inc.	100.00%	\$ 4,280	\$ 4,280	1
2	V	2 Food		Petersen Health Care Management, Inc.	100.00%	78	78	2
3	V	3 Housekeeping		Petersen Health Care Management, Inc.	100.00%	75	75	3
4	V	5 Utilities		Petersen Health Care Management, Inc.	100.00%	249	249	4
5	V	6 Maintenance		Petersen Health Care Management, Inc.	100.00%	2,337	2,337	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%	127	127	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	260,400	Petersen Health Care Management, Inc.	100.00%	63,249	(197,151)	11
12	V	19 Professional Services		Petersen Health Care Management, Inc.	100.00%	10,900	10,900	12
13	V							13
14	Total		\$ 260,400			\$ 81,295	\$ * (179,105)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	20 Dues, Fees, Subs & Promotions	\$	Petersen Health Care Management, Inc.	100.00%	\$ 456	\$	456	15
16	V	21 Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	49,899		49,899	16
17	V	22 Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	27,902		27,902	17
18	V	23 Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	96		96	18
19	V	24 Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	46		46	19
20	V	25 Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	3,926		3,926	20
21	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	553		553	21
22	V	27 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		0	22
23	V	30 Depreciation		Petersen Health Care Management, Inc.	100.00%	11,042		11,042	23
24	V	32 Interest		Petersen Health Care Management, Inc.	100.00%	324		324	24
25	V	33 Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	254		254	25
26	V	35 Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	898		898	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	<b>Total</b>		\$			\$ 95,396	\$ *	95,396	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1 Dietary	\$	Petersen Health Network, LLC	100.00%	\$ 0	\$	15	
16	V	2 Food		Petersen Health Network, LLC	100.00%	0		16	
17	V	3 Housekeeping		Petersen Health Network, LLC	100.00%	0		17	
18	V	4 Laundry		Petersen Health Network, LLC	100.00%	0		18	
19	V	5 Utilities		Petersen Health Network, LLC	100.00%	0		19	
20	V	6 Maintenance		Petersen Health Network, LLC	100.00%	0		20	
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Network, LLC	100.00%	0		21	
22	V	10 Nursing and Medical Records		Petersen Health Network, LLC	100.00%	0		22	
23	V	15 Mgmt. Allocation of Benefits		Petersen Health Network, LLC	100.00%	0		23	
24	V	17 Administrative		Petersen Health Network, LLC	100.00%	0		24	
25	V	19 Professional Services		Petersen Health Network, LLC	100.00%	3,506	3,506	25	
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Network, LLC	100.00%	0		26	
27	V	21 Clerical and General Office		Petersen Health Network, LLC	100.00%	0		27	
28	V	22 Employee Benefits & Payroll		Petersen Health Network, LLC	100.00%	0		28	
29	V	23 Inservice Training & Education		Petersen Health Network, LLC	100.00%	0		29	
30	V	24 Travel and Seminar		Petersen Health Network, LLC	100.00%	0		30	
31	V	25 Other Admin. Staff Transport.		Petersen Health Network, LLC	100.00%	0		31	
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Network, LLC	100.00%	0		32	
33	V	30 Depreciation		Petersen Health Network, LLC	100.00%	0		33	
34	V	31 Amortization		Petersen Health Network, LLC	100.00%	17,334	17,334	34	
35	V	32 Interest		Petersen Health Network, LLC	100.00%	1,538	1,538	35	
36	V	33 Real Estate Taxes		Petersen Health Network, LLC	100.00%	0		36	
37	V	34 Rent-Facility and Grounds		Petersen Health Network, LLC	100.00%	0		37	
38	V	35 Rent-Equipment & Vehicles		Petersen Health Network, LLC	100.00%	0		38	
39	Total		\$			\$ 22,378	\$ *	22,378	39

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

Facility Name &amp; ID Number

Havana Health Care Center

# 0053165

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, I	Peoria	Mgmt/Bookkeeping	1
2			Arcola Health Care Center	Arcola	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	2
3			Aspen Rehab & Health Care	Silvis	Petersen Health Care,	Peoria	Mgmt/Bookkeeping	3
4			Batavia Rehab & Health Care Center	Batavia	Petersen Health Enter	Peoria	Mgmt/Bookkeeping	4
5			Bement Health Care Center	Bement	Petersen Health Opera	Peoria	Mgmt/Bookkeeping	5
6			Benton Rehab & Health Care Center	Benton	Petersen Health Syster	Peoria	Mgmt/Bookkeeping	6
7			Bloomington Rehab & Health Care Center	Bloomington	Petersen Hotels LLC	Peoria	Hospitality	7
8			Casey Health Care Center	Casey	Petersen Hospitality L	Peoria	Hospitality	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen 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	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care	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 &amp; ID Number

Havana Health Care Center

# 0053165

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 &amp; ID Number

Havana Health Care Center

# 0053165

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

Havana Health Care Center

# 0053165

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 Havana Health Care Center # 0053165 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 Havana Health Care Center

# 0053165

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  NO

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,521,544	75	\$ 312,540	\$ 357,910	19,826	\$ 4,280	1
2	2	Food	Resident Days	1,521,544	75	5,673	0	19,826	78	2
3	3	Housekeeping	Resident Days	1,521,544	75	5,456	2,897	19,826	75	3
4	5	Utilities	Resident Days	1,521,544	75	18,209	0	19,826	249	4
5	6	Maintenance	Resident Days	1,521,544	75	170,632	137,057	19,826	2,337	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,521,544	75	0	0	19,826	0	6
7	9	Medical Director	Resident Days	1,521,544	75	0	0	19,826	0	7
8	10	Nursing and Medical Records	Resident Days	1,521,544	75	9,261	1,782,521	19,826	127	8
9	10A	Therapy	Resident Days	1,521,544	75	0	0	19,826	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,521,544	75	0	0	19,826	0	10
11	17	Administrative	Resident Days	1,521,544	75	4,806,228	5,473,961	19,826	63,249	11
12	19	Professional Services	Resident Days	1,521,544	75	795,918	0	19,826	10,900	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,521,544	75	33,278	0	19,826	456	13
14	21	Clerical and General Office	Resident Days	1,521,544	75	3,643,535	3,756,135	19,826	49,899	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,521,544	75	2,037,314	0	19,826	27,902	15
16	23	Inservice Training & Education	Resident Days	1,521,544	75	6,986	0	19,826	96	16
17	24	Travel and Seminar	Resident Days	1,521,544	75	3,389	0	19,826	46	17
18	25	Other Admin. Staff Transport.	Resident Days	1,521,544	75	286,637	0	19,826	3,926	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,521,544	75	40,378	0	19,826	553	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,521,544	75	0	0	19,826	0	20
21	30	Depreciation	Resident Days	1,521,544	75	806,271	0	19,826	11,042	21
22	32	Interest	Resident Days	1,521,544	75	23,686	0	19,826	324	22
23	33	Real Estate Taxes	Resident Days	1,521,544	75	18,560	0	19,826	254	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,521,544	75	65,550	0	19,826	898	24
25	TOTALS					\$ 13,089,501	\$ 11,510,481		\$ 176,691	25

Facility Name & ID Number Havana Health Care Center

# 0053165

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  NO

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

Name of Related Organization Petersen Health Quality, 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	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	83,584	5	\$	\$	19,826	\$	1
2	2	Food	Resident Days	83,584	5			19,826		2
3	3	Housekeeping	Resident Days	83,584	5			19,826		3
4	4	Laundry	Resident Days	83,584	5			19,826		4
5	5	Utilities	Resident Days	83,584	5			19,826		5
6	6	Maintenance	Resident Days	83,584	5			19,826		6
7	7	Mgmt. Allocation of Benefits	Resident Days	83,584	5			19,826		7
8	10	Nursing and Medical Records	Resident Days	83,584	5			19,826		8
9	15	Mgmt. Allocation of Benefits	Resident Days	83,584	5			19,826		9
10	17	Administrative	Resident Days	83,584	5			19,826		10
11	19	Professional Services	Resident Days	83,584	5	14,064		19,826	3,506	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	83,584	5			19,826		12
13	21	Clerical and General Office	Resident Days	83,584	5			19,826		13
14	22	Employee Benefits & Payroll	Resident Days	83,584	5			19,826		14
15	23	Inservice Training & Education	Resident Days	83,584	5			19,826		15
16	24	Travel and Seminar	Resident Days	83,584	5			19,826		16
17	25	Other Admin. Staff Transport.	Resident Days	83,584	5			19,826		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	83,584	5			19,826		18
19	30	Depreciation	Resident Days	83,584	5			19,826		19
20	31	Amortization	Resident Days	83,584	5	69,527		19,826	17,334	20
21	32	Interest	Resident Days	83,584	5	6,168		19,826	1,538	21
22	33	Real Estate Taxes	Resident Days	83,584	5			19,826		22
23	34	Rent-Facility and Grounds	Resident Days	83,584	5			19,826		23
24	35	Rent-Equipment & Vehicles	Resident Days	83,584	5			19,826		24
25	TOTALS					\$ 89,759	\$		\$ 22,378	25

Facility Name & ID Number

Havana Health Care Center

# 0053165

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	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	Gemino		X	Mortgage	Varies	3/27/15	\$ 1,677,770	\$ 1,605,819	3/26/40	Varies	\$ 86,088	1						
2												2						
3												3						
4												4						
5												5						
<b>Working Capital</b>																		
6												6						
7												7						
8												8						
9	<b>TOTAL Facility Related</b>						\$ 1,677,770	\$ 1,605,819			\$ 86,088	9						
<b>B. Non-Facility Related*</b>																		
10									Interest Income Offset		(522)	10						
11									Home Office Allocation-PHQ		1,538	11						
12									Home Office Allocation-PHCM		324	12						
13												13						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ 1,340	14						
15	<b>TOTALS (line 9+line14)</b>						\$ 1,677,770	\$ 1,605,819			\$ 87,428	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.)

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

**B. Real Estate Taxes**

**Important, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.**

1. Real Estate Tax accrual used on 2015 report.		\$	<b>74,064</b>	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.)		\$	<b>15</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(74,049)</b>	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>151,391</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	<b>254</b>	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>77,596</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2011	<b>86,165</b>	8
	2012	<b>71,692</b>	9
	2013	<b>72,283</b>	10
	2014	<b>71,908</b>	11
	2015	<b>74,582</b>	12

**Accrual based on prior year tax bill.**

<b>FOR BHF USE ONLY</b>			
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 Havana Health Care Center COUNTY Mason

FACILITY IDPH LICENSE NUMBER 0053165

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)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>05-31-300-006</u>	<u>Long-Term Care Facility</u>	\$ <u>74,551.54</u>	\$ <u>74,551.54</u>
2. <u>05-31-304-013</u>	<u>Land</u>	\$ <u>30.42</u>	\$ <u>30.42</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ <u><u>74,581.96</u></u>	\$ <u><u>74,581.96</u></u>

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

Attach a copy of the original 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 Havana Health Care Center

# 0053165 Report Period Beginning:

1/1/2016 Ending:

12/31/2016

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,208 B. General Construction Type: Exterior Brick Frame Steel 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? [X] YES [ ] NO If so, please complete the following:

1. Total Amount Incurred: 95,556 2. Number of Years Over Which it is Being Amortized: 20 3. Current Period Amortization: 17,334 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:

Table with 6 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, 5, 6. Row 1: Facility, 418,945, 2001, \$ 200,000, 1. Row 2: 2, 2. Row 3: TOTALS, 418,945, \$ 200,000, 3.

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	98	2001	1971	\$ 1,314,000	\$	35	\$ 37,543	\$ 37,543	\$ 581,916	4
5										5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9	Flooring	2001		5,875		20	295	295	4,572	9
10	Landscaping	2001		8,984		20	449	449	6,960	10
11	A/C Heating Unit	2001		2,046		20	102	102	1,705	11
12	Ceiling Tiles	2003		9,516		20	476	476	6,426	12
13	Doors	2004		2,305		20	115	115	1,438	13
14	Nursing Station	2004		8,100		20	405	405	5,063	14
15	Furnace	2004		3,382		20	169	169	2,113	15
16	Water Heater	2004		2,281		20	114	114	1,425	16
17	Concrete slab work	2005		3,919		20	196	196	2,254	17
18	Roofing	2006		2,991		20	150	150	1,575	18
19	Walk-In Freezer	2007		14,817		20	741	741	7,039	19
20	Roof Repairs	2008		2,890		20	144	144	1,224	20
21	A/C Unit	2010		3,091		7	442	442	2,873	21
22	Fire Alarm Panel	2010		2,648		7	378	378	2,457	22
23	Roof Repairs	2010		10,896		7	1,556	1,556	10,114	23
24	Sprinkler System Replacement	2010		96,315		15	6,422	6,422	41,743	24
25	Wastewater Pump	2011		8,141		10	814	814	4,477	25
26	Generator Installation	2011		7,000		10	700	700	3,850	26
27	Water Heater	2013		3,673		7	262	262	3,935	27
28	Water Heater	2013		3,572		7	510	510	1,785	28
29	A/C Condenser	2013		6,265		15	418	418	1,463	29
30	Roof Replacement	2013		157,330		25	6,294	6,294	22,029	30
31	Landscaping	2013		3,600		15	240	240	840	31
32	Water Heater	2013		9,713		7	1,388	1,388	4,858	32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Sprinkler System Repair	2014	\$ 5,807	\$	7	\$ 830	\$ 830	\$ 2,075	37
38	Sprinkler Head Installations	2014	4,955		7	708	708	1,770	38
39	Parking Lot Repaving	2014	55,985		15	3,732	3,732	9,330	39
40	Landscaping	2014	6,237		7	891	891	2,228	40
41	Nursing Alarm System Replacement	2014	14,699		7	2,100	2,100	5,250	41
42	Exterior Fencing Around Facility	2014	5,150		15	343	343	858	42
43	Soffit Replacements	2014	11,122		15	741	741	1,853	43
44	Tile, Floor, Painting in Bedrooms, Common Areas, Hallways	2014	218,407		15	14,560	14,560	36,400	44
45	Awning	2014	3,159		7	226	226	565	45
46	Nurses Station	2014	11,341		15	756	756	1,890	46
47	Exterior Signage	2015	3,397		7	486	486	729	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	Land Improvements Booked			265			(265)		63
64	Building Booked			33,692			(33,692)		64
65	Building Improvement Booked			47,308			(47,308)		65
66									66
67	2016-Home Office Allocation-Building Improvements		9,200			221	221		67
68	2016-Home Office Allocation-Land Improvements		847			55	55		68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,043,656	\$ 81,265		\$ 85,972	\$ 4,707	\$ 787,082	70

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



Facility Name & ID Number Havana Health Care Center

# 0053165

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	\$ 162,038	\$ 21,123	\$ 12,597	\$ (8,526)	5-10 yrs.	\$ 47,211	71
72	Current Year Purchases	2,718	324	194	(130)	7 yrs.	194	72
73	Fully Depreciated Assets	418,605					418,605	73
74	Home Office Allocation			10,766	10,766			74
75	TOTALS	\$ 583,361	\$ 21,447	\$ 23,557	\$ 2,110		\$ 466,010	75

D. Vehicle Costs. (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Use	2009 Ford E250 Van	2009	34,172	\$	\$	\$	5 yrs.	\$ 34,172	76
77										77
78										78
79										79
80	TOTALS			\$ 34,172	\$	\$	\$		\$ 34,172	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)	\$ 2,861,189	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 102,712	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 109,529	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 6,817	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,287,264	85

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

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

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			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 Havana Health Care Center

# 0053165

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	<b>TOTAL</b>				\$			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending                      Annual Rent

12.	_____ /2017	\$ _____
13.	_____ /2018	\$ _____
14.	_____ /2019	\$ _____

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

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

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_\*

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 38,505 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			\$	\$	17
18	<u>N/A</u>				18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	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.

**Havana Health Care Center**

**0053165**

**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	\$ 34,889
Dishwasher	704
Copier	2,014
Home Office Allocation	898
	<u>38,505</u>

**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)**

**A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)**

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility			
		1	2	3	4
		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	<b>TOTALS</b>	\$	\$	\$	\$
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)	
<b>TOTAL TRAINED</b>	

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	6,845	\$ 102,674	\$	6,845	\$ 102,674	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		401	6,010		401	6,010	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		8,982	134,381		8,982	134,381	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				46,479		46,479	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Respiratory Therapy</u>	10A(3)			23	347		23	347	12
13	Other (specify):									13
14	<b>TOTAL</b>			\$	16,251	\$ 243,412	\$ 46,479	16,251	\$ 289,891	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 Havana Health Care Center

# 0053165

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	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 325,823	\$ 325,823	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 48,309 )	969,061	969,061	3
4	Supply Inventory (priced at Cost )	15,521	15,521	4
5	Short-Term Investments			5
6	Prepaid Insurance	28,758	28,758	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Security Deposit & EE Advances	5,323	5,323	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,344,486	\$ 1,344,486	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	208,984	200,000	13
14	Buildings, at Historical Cost	1,314,000	1,323,200	14
15	Leasehold Improvements, at Historical Cost	719,609	720,456	15
16	Equipment, at Historical Cost	617,533	617,533	16
17	Accumulated Depreciation (book methods)	(1,261,687)	(1,287,264)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	145,315	145,315	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,743,754	\$ 1,719,240	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,088,240	\$ 3,063,726	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 784,168	\$ 784,168	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	93,017	93,017	30
31	Accrued Taxes Payable (excluding real estate taxes)	39,176	39,176	31
32	Accrued Real Estate Taxes(Sch.IX-B)	151,391	151,391	32
33	Accrued Interest Payable	6,551	6,551	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	Payroll Withholdings	105,471	105,471	36
37	Accrued Management Fees	421,120	421,120	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,600,894	\$ 1,600,894	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,605,819	1,605,819	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 1,605,819	\$ 1,605,819	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 3,206,713	\$ 3,206,713	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (118,473)	\$ (142,987)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,088,240	\$ 3,063,726	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(346,746)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Prior Period Adjustments Made After Cost Report Was Filed</b>	<b>(11,002)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(357,748)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>239,275</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>239,275</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(118,473)</b>	<b>24</b> *

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

Facility Name &amp; ID Number Havana Health Care Center

# 0053165

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		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,305,604	1
2	Discounts and Allowances for all Levels	(402,436)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,903,168	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	455,475	6
7	Oxygen	2,117	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 457,592	8
<b>C. Other Operating Revenue</b>			
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	10,460	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	76,106	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	69,491	20
21	Other Medical Services	15,168	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 171,225	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	522	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 522	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Transportation Revenue</u>	8,231	28
28a	<u>Jail Meals and Miscellaneous Revenue</u>	34,263	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 42,494	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,575,001	30

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	686,132	31
32	Health Care	1,472,858	32
33	General Administration	580,260	33
<b>B. Capital Expense</b>			
34	Ownership	303,749	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	125,756	35
36	Provider Participation Fee	166,971	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,335,726	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	239,275	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 239,275	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 1,875,368	44
45	Private Pay - Net Inpatient Revenue	632,932	45
46	Medicare - Net Inpatient Revenue	294,280	46
47	Other-(specify) <u>Insurance Net Inpatient Revenue</u>	100,588	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 2,903,168	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 Havana Health Care Center

# 0053165

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	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,080	2,080	\$ 47,640	\$ 22.90	1
2	Assistant Director of Nursing	48	48	811	16.90	2
3	Registered Nurses	4,873	5,050	110,590	21.90	3
4	Licensed Practical Nurses	13,454	13,887	269,274	19.39	4
5	CNAs & Orderlies	40,125	41,033	455,756	11.11	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,683	1,683	19,962	11.86	9
10	Activity Assistants	849	849	9,055	10.67	10
11	Social Service Workers	2,870	2,870	44,050	15.35	11
12	Dietician					12
13	Food Service Supervisor	2,045	2,045	31,497	15.40	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,582	13,065	126,036	9.65	15
16	Dishwashers					16
17	Maintenance Workers	2,974	3,127	48,068	15.37	17
18	Housekeepers	7,889	8,004	89,664	11.20	18
19	Laundry	3,503	3,677	43,960	11.96	19
20	Administrator	2,080	2,080	63,249	30.41	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,232	2,232	35,126	15.74	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	4,925	5,030	114,999	22.86	32
33	Other(specify) <u>Transportation</u>	1,760	1,820	16,759	9.21	33
34	TOTAL (lines 1 - 33)	105,972	108,580	\$ 1,526,496 *	\$ 14.06	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant			35	
36	Medical Director	Monthly	19,200	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,708	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)		\$ 23,908		49

**C. CONTRACT NURSES**

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

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Stephanie Clements	Administrator	0	\$ 63,249	Workers' Compensation Insurance	\$ 49,163	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance	42,988	Advertising: Employee Recruitment	269	
				FICA Taxes	110,606	Health Care Worker Background Check (Indicate # of checks performed <u>90</u> )	980	
				Employee Health Insurance	3,292	Patient Background Checks <u>53</u>	980	
				Employee Meals		Miscellaneous Licenses & Permits	487	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Dues & Subscriptions	1,075	
				Employee Relations	1,169	Home Office Allocation	456	
				Employee Retirement	27,902			
				Home Office Allocation	390			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 63,249	TOTAL (agree to Schedule V, line 22, col.8)		\$ 6,237		
B. Administrative - Other							Less: Public Relations Expense ( )	
Description			Amount				Non-allowable advertising ( )	
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 260,400				Yellow page advertising ( )	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 260,400				TOTAL (agree to Sch. V, line 20, col. 8)	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Honkamp Krueger & Co.	Accounting Fees		\$ 826				Out-of-State Travel	\$
E-Health Data Solutions	Computer Services		2,941					
CenturyLink	Computer Services		1,319	N/A			In-State Travel	
Cass Communications	Computer Services		1,024					
Ability Network	Computer Services		102				Seminar Expense	
Sorling Northrup	Legal Fees		3,105				Home Office Allocation	46
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 9,317	TOTAL		\$	Entertainment Expense ( )	
							TOTAL (agree to Sch. V, line 24, col. 8)	
							\$ 46	

\* Attach copy of IMRF notifications

\*\*See instructions.

Havana Health Care Center

0053165

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)		9,317

Home Office Allocation

Lucie, Scalf, and Bougher	Legal	49
Miscellaneous	Legal	18
Miller Hall and Triggs	Legal	84
Healthcare Resources International	Legal	420
Hunziker Law	Legal	100
Lexis Nexis	Legal	9
Gemino	Legal	311
Illinois Secretary of State	Legal	62
Peoria County Recorder	Legal	25
CliftonLarson Allen	Accountants	554
Ginoli & Co.	Accountants	4,417
Miscellaneous	Computer Services	55
Change Healthcare	Computer Services	8
PTC Select	Computer Services	5
Advanced Answers on Demand	Computer Services	3,837
Stratus Networks	Computer Services	390
Kemper Technology	Computer Services	257
AT&T	Computer Services	6
Ability Network	Computer Services	1,636
CIAN	Computer Services	195
Comcast	Computer Services	32
CCH	Computer Services	13
Charter Communications	Computer Services	38
Allscripts	Computer Services	571
ATS	Computer Services	257
Allpayer Exchange	Computer Services	13
Optimizer	Other Prof Fees	39
Ankura	Other Prof Fees	298
David Budde	Other Prof Fees	34
Bruner, Cooper, Zuck	Other Prof Fees	87
Marotta, Gund, Budd, Dzerda	Other Prof Fees	536
Professional Software and Services	Other Prof Fees	21
Hughes Valuation Services	Other Prof Fees	27
Alan Litwiller	Other Prof Fees	2

Total (agree to Schedule V, line 19, column 8)

23,723

Facility Name & ID Number Havana Health Care Center# 0053165Report Period Beginning: 1/1/2016Ending: 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. IHCA-\$1,000
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 7 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 25,533 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 166,971  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 10,460
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 8,231  
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 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 Detail	-198,309	equal to	-198,309	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	87,428	equal to	87,428	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	77,596	equal to	77,596	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	17,334	equal to	17,334	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	109,529	equal to	109,529	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	38,505	equal to	38,505	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	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 Services	243,412	equal to	243,412	0	O.K.	Pg16 Z12+Z14..	N/A;B	1-4,40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv.- Supplies	46,479	equal to	46,479	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	686,132	equal to	686,132	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	1,472,858	equal to	1,472,858	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	580,260	equal to	580,260	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	303,749	equal to	303,749	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	125,756	equal to	125,756	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+I	N/A	38to41+43	4
Income Stat. Prov. Partic.	166,971	equal to	166,971	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	999,070	equal to	999,070	0	O.K.	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to	0	0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	45,776	equal to	45,776	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	44,050	equal to	44,050	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	157,533	equal to	157,533	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	48,068	equal to	48,068	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	89,664	equal to	89,664	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	43,960	equal to	43,960	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	63,249	equal to	63,249	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	35,126	equal to	35,126	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to	0	0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	1,526,496	equal to	1,463,247	63,249	FAILED	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	0	< or = to		#VALUE!	#VALUE!	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	19,200	< or = to	19,200	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	4,708	< or = to	12,295	-7,587	O.K.	Pg20 X14..X16+	B. & C.	7to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to	84	-84	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	0	< or = to	0	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	63,249	equal to	63,249	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	260,400	equal to	260,400	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	9,317	equal to	9,317	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	235,510	equal to	235,510	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	6,237	equal to	6,237	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	46	equal to	46	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	166,971	equal to	166,971	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to	0	0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	1,685	equal to	2,290	-605	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	-61,331	equal to	-61,331	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4	B.	14	8
Total loan balance	1,605,819	equal to	1,605,819	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27.	N/A	29+39-41	2
Real estate tax accrual	151,391	equal to	151,391	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	200,000	equal to	200,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	2,043,656	equal to	2,043,656	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	617,533	equal to	617,533	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	1,287,264	equal to	1,287,264	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	-118,473	equal to	-118,473	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	239,275	equal to	239,275	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to	0	0	O.K.	Pg22 F31-J31..I	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	3,088,240	equal to	3,088,240	0	O.K.	Pg17:H41	N/A	25	1	Pg17 S41	N/A	48	1



	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Adjusted Total
1. Dietary	157,533	25,472	0	183,005	0	183,005	4,280	187,285
2. Food Purchase	0	190,482	0	190,482	0	190,482	-44,512	145,970
3. Housekeeping	89,664	12,692	0	102,356	0	102,356	75	102,431
4. Laundry	43,960	8,363	0	52,323	0	52,323	0	52,323
5. Heat and Other Utilities	0	0	67,027	67,027	0	67,027	249	67,276
6. Maintenance	48,068	6,369	36,502	90,939	0	90,939	2,337	93,276
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	339,225	243,378	103,529	686,132	0	686,132	-37,571	648,561
9. Medical Director	0	0	19,200	19,200	0	19,200	0	19,200
10. Nursing & Medical Records	999,070	108,697	12,295	1,120,062	0	1,120,062	127	#####
10a. Therapy	0	0	243,412	243,412	0	243,412	0	243,412
11. Activities	45,776	274	84	46,134	0	46,134	-8,231	37,903
12. Social Services	44,050	0	0	44,050	0	44,050	0	44,050
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	1,088,896	108,971	274,991	1,472,858	0	1,472,858	-8,104	#####
17. Administrative	0	0	260,400	260,400	0	260,400	-197,151	63,249
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	9,317	9,317	0	9,317	14,406	23,723
20. Fees, Subscriptions & Promotion	0	0	5,781	5,781	0	5,781	456	6,237
21. Clerical & General Office	35,126	7,432	11,551	54,109	0	54,109	49,766	103,875
22. Employee Benefits & Payroll	0	0	207,608	207,608	0	207,608	27,902	235,510
23. Inservice Training & Education	0	0	0	0	0	0	96	96
24. Travel and Seminar	0	0	0	0	0	0	46	46
25. Other Admin. Staff Trans	0	0	11,966	11,966	0	11,966	3,926	15,892
26. Insurance-Prop.Liab.Malpractice	0	0	31,079	31,079	0	31,079	553	31,632
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	35,126	7,432	537,702	580,260	0	580,260	-100,000	480,260
29. Total General Administrative	1,463,247	359,781	916,222	2,739,250	0	2,739,250	-145,675	#####
30. Depreciation	0	0	102,712	102,712	0	102,712	6,817	109,529
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	17,334	17,334
32. Interest	0	0	86,088	86,088	0	86,088	1,340	87,428
33. Real Estate	0	0	77,342	77,342	0	77,342	254	77,596
34. Rent - Facility & Grounds	0	0	0	0	0	0	0	0
35. Rent - Equipment & Vehicles	0	0	37,607	37,607	0	37,607	898	38,505
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	303,749	303,749	0	303,749	26,643	330,392
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	46,479	0	46,479	0	46,479	0	46,479
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	166,971	166,971	0	166,971	0	166,971
43. Other (specify):*	0	1,270	78,007	79,277	0	79,277	-79,277	0
44. Total Special Cost Ce	0	47,749	244,978	292,727	0	292,727	-79,277	213,450
45. Grand Total	1,463,247	407,530	1,464,949	3,335,726	0	3,335,726	-198,309	#####

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	325,823	325,823
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	969,061	969,061
4. Supply Inventory	15,521	15,521
5. Short-Term Investments	0	0
6. Prepaid Insurance	28,758	28,758
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	5,323	5,323
10. Total current assets	1,344,486	1,344,486
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	208,984	200,000
14. Buildings, at Historical Cost	1,314,000	1,323,200
15. Leasehold Improvements, Historical Cost	719,609	720,456
16. Equipment, at Historical Cost	617,533	617,533
17. Accumulated Depreciation (book methods) #####		-1,287,264
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	145,315	145,315
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	0
24. Total Long-Term Assets	1,743,754	1,719,240
25. Total Assets	3,088,240	3,063,726
CURRENT LIABILITIES		
26. Accounts Payable	784,168	784,168
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	93,017	93,017
31. Accrued Taxes Payable	39,176	39,176
32. Accrued Real Estate Taxes	151,391	151,391
33. Accrued Interest Payable	6,551	6,551
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	105,471	105,471
37. Other Current Liabilities (specify):	421,120	421,120
38. Total Current Liabilities	1,600,894	1,600,894
LONG TERM LIABILITES		
39. Long-Term Notes Payable	0	0
40. Mortgage Payable	1,605,819	1,605,819
41. Bonds Payable	0	0
42. Deferred Compensation	0	0
43. Other Long-Term Liabilities (specify):	0	0
44. Other Long-Term Liabilities (specify):	0	0
45. Total Long-Term Liabilities	1,605,819	1,605,819
46. Total Liabilities	3,206,713	3,206,713
47. Total Equity	-118,473	-142,987
48. Total Liabilities and Equity	3,088,240	3,063,726



	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	3,305,604
2. Discounts and Allowances for all Levels	-402,436
Subtotal - Inpatient Care	2,903,168
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	455,475
7. Oxygen	2,117
Subtotal - Ancillary Revenue	457,592
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	10,460
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	76,106
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiology and X-Ray	69,491
21. Other Medical Services	15,168
22. Laundry	0
Subtotal - Other Operating Revenue	171,225
24. Contributions	0
25. Interest and Other Investments Income	522
Subtotal - Non-Operating Revenue	522
27. Other Revenue (specify):	8,231
28. Other Revenue (specify):	34,263
Subtotal - Other Revenue	42,494
30. Total Revenue	3,575,001
31. General Services	742,615
32. Health Care	1,389,275
33. General Administration	567,375
34. Ownership	266,187
35. Special Cost Centers	247,022
35. Provider Participation Fee	159,824
37. Other	0
40. Total Expenses	3,372,298
41. Income Before Income Taxes	202,703
42. Income Taxes	0
43. Net Income or Loss for the Year	202,703