FOR BHF USE

LL1

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

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: 0053488

Facility Name: Westside Rehab & Care Center

Address: 601 N Columbia St (Number) West Frankfort (City) 62896 (Zip Code)

County: Franklin

Telephone Number: (618) 932-2109 **Fax #** (618) 937-3289

HFS ID Number:

Date of Initial License for Current Owners: 3/1/2009

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2016 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 Westside Rehab & Care Center # 0053488 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	96	Skilled (SNF)	96	35,040	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	96	TOTALS	96	35,040	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	10,772	3,057	1,373	15,202	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,772	3,057	1,373	15,202	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 43.38%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 3/1/2009

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 3/1/2009 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 96 and days of care provided 1,348

Medicare Intermediary Wisconsin Physicians Service

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 Westside Rehab & Care Center # 0053488 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	119,077	7,688	1,428	128,193		128,193	3,123	131,316			1
2	Food Purchase		94,294		94,294		94,294	(3,333)	90,961			2
3	Housekeeping	84,617	10,500		95,117		95,117	55	95,172			3
4	Laundry	4,494	6,055	10	10,559		10,559		10,559			4
5	Heat and Other Utilities			52,348	52,348		52,348	182	52,530			5
6	Maintenance	35,838	3,822	17,223	56,883		56,883	1,705	58,588			6
7	Other (specify):* Home Office Ben. Allocation											7
8	TOTAL General Services	244,026	122,359	71,009	437,394		437,394	1,732	439,126			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	681,191	98,517	4,534	784,242		784,242	(3,048)	781,194			10
10a	Therapy		71	130,363	130,434		130,434		130,434			10a
11	Activities	41,958	233	241	42,432		42,432	(9,732)	32,700			11
12	Social Services	20,958	5		20,963		20,963		20,963			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Office Ben. Allocation											15
16	TOTAL Health Care and Programs	744,107	98,826	147,138	990,071		990,071	(12,780)	977,291			16
	C. General Administration											
17	Administrative			191,100	191,100		191,100	(126,100)	65,000			17
18	Directors Fees											18
19	Professional Services			17,102	17,102		17,102	16,006	33,108			19
20	Dues, Fees, Subscriptions & Promotions			4,759	4,759		4,759	182	4,941			20
21	Clerical & General Office Expenses	28,483	1,676	9,742	39,901		39,901	36,361	76,262			21
22	Employee Benefits & Payroll Taxes			137,514	137,514		137,514	20,355	157,869			22
23	Inservice Training & Education							70	70			23
24	Travel and Seminar			10	10		10	34	44			24
25	Other Admin. Staff Transportation			4,263	4,263		4,263	2,864	7,127			25
26	Insurance-Prop.Liab.Malpractice			29,133	29,133		29,133	403	29,536			26
27	Other (specify):* Home Office Ben. Allocation											27
28	TOTAL General Administration	28,483	1,676	393,623	423,782		423,782	(49,825)	373,957			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,016,616	222,861	611,770	1,851,247		1,851,247	(60,873)	1,790,374			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 Westside Rehab & Care Center #0053488 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			69,832	69,832		69,832	26,185	96,017			30
31	Amortization of Pre-Op. & Org.							4,922	4,922			31
32	Interest			97,650	97,650		97,650	22,763	120,413			32
33	Real Estate Taxes			30,441	30,441		30,441	185	30,626			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			16,746	16,746		16,746	655	17,401			35
36	Other (specify):*											36
37	**TOTAL Ownership**			214,669	214,669		214,669	54,710	269,379			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		79,097		79,097		79,097		79,097			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			136,562	136,562		136,562		136,562			42
43	Other (specify):*		115	43,699	43,814		43,814	(43,814)				43
44	**TOTAL Special Cost Centers**		79,212	180,261	259,473		259,473	(43,814)	215,659			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,016,616	302,073	1,006,700	2,325,389		2,325,389	(49,977)	2,275,412			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 Westside Rehab & Care Center # 0053488 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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,390)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,919)	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	18,129	30		9
10	Interest and Other Investment Income	(38)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(472)	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	(20,086)	43		18
19	Entertainment				19
20	Contributions	(20)	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	(4,500)	43		24
25	Fund Raising, Advertising and Promotional	(2,884)	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	(24,998)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (42,178)		$	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)	(7,799)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (7,799)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (49,977)		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

Westside Rehab & Care Center

ID# 0053488

Report Period Beginning: 1/1/2016

Ending: 12/31/2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs-Part A	$ (7,104)	43	1
2	X-Rays-Part A	(4,663)	43	2
3	Disallowed Special Events	83	43	3
4	Offset Miscellaneous Office Supplies Revenue	(42)	21	4
5	Pet Expense	(249)	43	5
6	Offset Transportation Revenue	(9,732)	11	6
7	Disallowed Chamber of Commerce Dues	(150)	20	7
8	Offset Miscellaneous Nursing Supplies Revenue	(3,141)	10	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**	(24,998)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Westside Rehab & Care Center # 0053488 **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	3,123	0	0	0	0	0	0	0	0	0	3,123	1
2	Food Purchase	(3,390)	57	0	0	0	0	0	0	0	0	0	(3,333)	2
3	Housekeeping	0	55	0	0	0	0	0	0	0	0	0	55	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	182	0	0	0	0	0	0	0	0	0	182	5
6	Maintenance	0	1,705	0	0	0	0	0	0	0	0	0	1,705	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(3,390)	5,122	0	0	0	0	0	0	0	0	0	1,732	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	(3,141)	93	0	0	0	0	0	0	0	0	0	(3,048)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(9,732)	0	0	0	0	0	0	0	0	0	0	(9,732)	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**	(12,873)	93	0	0	0	0	0	0	0	0	0	(12,780)	16
	C. General Administration													
17	Administrative	0	(126,100)	0	0	0	0	0	0	0	0	0	(126,100)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	7,952	0	0	0	0	0	0	0	0	0	7,952	19
20	Fees, Subscriptions & Promotions	(150)	0	332	0	0	0	0	0	0	0	0	182	20
21	Clerical & General Office Expenses	(42)	0	36,403	8,054	0	0	0	0	0	0	0	44,415	21
22	Employee Benefits & Payroll Taxes	0	0	20,355	0	0	0	0	0	0	0	0	20,355	22
23	Inservice Training & Education	0	0	70	0	0	0	0	0	0	0	0	70	23
24	Travel and Seminar	0	0	34	0	0	0	0	0	0	0	0	34	24
25	Other Admin. Staff Transportation	0	0	2,864	0	0	0	0	0	0	0	0	2,864	25
26	Insurance-Prop.Liab.Malpractice	0	0	403	0	0	0	0	0	0	0	0	403	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(192)	(118,148)	60,461	8,054	0	0	0	0	0	0	0	(49,825)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(16,455)	(112,933)	60,461	8,054	0	0	0	0	0	0	0	(60,873)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Westside Rehab & Care Center # 0053488 **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	18,129	0	8,056	0	0	0	0	0	0	0	0	26,185	30
31	Amortization of Pre-Op. & Org.	0	0	0	4,922	0	0	0	0	0	0	0	4,922	31
32	Interest	(38)	0	237	22,564	0	0	0	0	0	0	0	22,763	32
33	Real Estate Taxes	0	0	185	0	0	0	0	0	0	0	0	185	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	655	0	0	0	0	0	0	0	0	655	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	18,091	0	9,133	27,486	0	0	0	0	0	0	0	54,710	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):*	(43,814)	0	0	0	0	0	0	0	0	0	0	(43,814)	43
44	**TOTAL Special Cost Centers**	(43,814)	0	0	0	0	0	0	0	0	0	0	(43,814)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(42,178)	(112,933)	69,594	35,540	0	0	0	0	0	0	0	(49,977)	45

Facility Name & ID Number Westside Rehab & Care Center # 0053488 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%	$ 3,123	$ 3,123	1
2	V	2	Food		Petersen Health Care Management, Inc.	100.00%	57	57	2
3	V	3	Housekeeping		Petersen Health Care Management, Inc.	100.00%	55	55	3
4	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	182	182	4
5	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	1,705	1,705	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%	93	93	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	191,100	Petersen Health Care Management, Inc.	100.00%	65,000	(126,100)	11
12	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	7,952	7,952	12
13	V								13
14	Total			$ 191,100			$ 78,167	$ * (112,933)	14

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

Facility Name & ID Number Westside Rehab & Care Center # 0053488 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%	$ 332	$ 332	15
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	36,403	36,403	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	20,355	20,355	17
18	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	70	70	18
19	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	34	34	19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	2,864	2,864	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	403	403	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%	8,056	8,056	23
24	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	237	237	24
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	185	185	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	655	655	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			$			$ 69,594	$ * 69,594	39

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

Facility Name & ID Number Westside Rehab & Care Center # 0053488 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 Business, LLC	100.00%	$ 0	$	15
16	V	2	Food		Petersen Health Business, LLC	100.00%	0		16
17	V	3	Housekeeping		Petersen Health Business, LLC	100.00%	0		17
18	V	4	Laundry		Petersen Health Business, LLC	100.00%	0		18
19	V	5	Utilities		Petersen Health Business, LLC	100.00%	0		19
20	V	6	Maintenance		Petersen Health Business, LLC	100.00%	0		20
21	V	7	Mgmt. Allocation of Benefits		Petersen Health Business, LLC	100.00%	0		21
22	V	10	Nursing and Medical Records		Petersen Health Business, LLC	100.00%	0		22
23	V	15	Mgmt. Allocation of Benefits		Petersen Health Business, LLC	100.00%	0		23
24	V	17	Administrative		Petersen Health Business, LLC	100.00%	0		24
25	V	19	Professional Services		Petersen Health Business, LLC	100.00%	0		25
26	V	20	Dues, Fees, Subs & Promotions		Petersen Health Business, LLC	100.00%	0		26
27	V	21	Clerical and General Office		Petersen Health Business, LLC	100.00%	8,054	8,054	27
28	V	22	Employee Benefits & Payroll		Petersen Health Business, LLC	100.00%	0		28
29	V	23	Inservice Training & Education		Petersen Health Business, LLC	100.00%	0		29
30	V	24	Travel and Seminar		Petersen Health Business, LLC	100.00%	0		30
31	V	25	Other Admin. Staff Transport.		Petersen Health Business, LLC	100.00%	0		31
32	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Business, LLC	100.00%	0		32
33	V	30	Depreciation		Petersen Health Business, LLC	100.00%	0		33
34	V	31	Amortization		Petersen Health Business, LLC	100.00%	4,922	4,922	34
35	V	32	Interest		Petersen Health Business, LLC	100.00%	22,564	22,564	35
36	V	33	Real Estate Taxes		Petersen Health Business, LLC	100.00%	0		36
37	V	34	Rent-Facility and Grounds		Petersen Health Business, LLC	100.00%	0		37
38	V	35	Rent-Equipment & Vehicles		Petersen Health Business, LLC	100.00%	0		38
39	Total			$			$ 35,540	$ * 35,540	39

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

Facility Name & ID Number Westside Rehab & Care Center # 0053488 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 Westside Rehab & Care Center # 0053488 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 Westside Rehab & Care Center # 0053488 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 Westside Rehab & Care Center # 0053488 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 Westside Rehab & Care Center # 0053488 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 Westside Rehab & Care Center # 0053488 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 Management, Inc.
Street Address: 830 W. Trailcreek Drive
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 691-8113
Fax Number: (309) 691-8622

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	1,521,544	75	$ 312,540	$ 357,910	15,202	$ 3,123	1
2	2	Food	Resident Days	1,521,544	75	5,673	0	15,202	57	2
3	3	Housekeeping	Resident Days	1,521,544	75	5,456	2,897	15,202	55	3
4	5	Utilities	Resident Days	1,521,544	75	18,209	0	15,202	182	4
5	6	Maintenance	Resident Days	1,521,544	75	170,632	137,057	15,202	1,705	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,521,544	75	0	0	15,202	0	6
7	9	Medical Director	Resident Days	1,521,544	75	0	0	15,202	0	7
8	10	Nursing and Medical Records	Resident Days	1,521,544	75	9,261	1,782,521	15,202	93	8
9	10A	Therapy	Resident Days	1,521,544	75	0	0	15,202	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,521,544	75	0	0	15,202	0	10
11	17	Administrative	Resident Days	1,521,544	75	4,806,228	5,473,961	15,202	65,000	11
12	19	Professional Services	Resident Days	1,521,544	75	795,918	0	15,202	7,952	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,521,544	75	33,278	0	15,202	332	13
14	21	Clerical and General Office	Resident Days	1,521,544	75	3,643,535	3,756,135	15,202	36,403	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,521,544	75	2,037,314	0	15,202	20,355	15
16	23	Inservice Training & Education	Resident Days	1,521,544	75	6,986	0	15,202	70	16
17	24	Travel and Seminar	Resident Days	1,521,544	75	3,389	0	15,202	34	17
18	25	Other Admin. Staff Transport.	Resident Days	1,521,544	75	286,637	0	15,202	2,864	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,521,544	75	40,378	0	15,202	403	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,521,544	75	0	0	15,202	0	20
21	30	Depreciation	Resident Days	1,521,544	75	806,271	0	15,202	8,056	21
22	32	Interest	Resident Days	1,521,544	75	23,686	0	15,202	237	22
23	33	Real Estate Taxes	Resident Days	1,521,544	75	18,560	0	15,202	185	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,521,544	75	65,550	0	15,202	655	24
25	TOTALS					$ 13,089,501	$ 11,510,481		$ 147,761	25

Facility Name & ID Number Westside Rehab & Care Center # 0053488 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 Business, 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	171,230	9	$	$	15,202	$	1
2	2	Food	Resident Days	171,230	9			15,202		2
3	3	Housekeeping	Resident Days	171,230	9			15,202		3
4	4	Laundry	Resident Days	171,230	9			15,202		4
5	5	Utilities	Resident Days	171,230	9			15,202		5
6	6	Maintenance	Resident Days	171,230	9			15,202		6
7	7	Mgmt. Allocation of Benefits	Resident Days	171,230	9			15,202		7
8	10	Nursing and Medical Records	Resident Days	171,230	9			15,202		8
9	15	Mgmt. Allocation of Benefits	Resident Days	171,230	9			15,202		9
10	17	Administrative	Resident Days	171,230	9			15,202		10
11	19	Professional Services	Resident Days	171,230	9			15,202		11
12	20	Dues, Fees, Subs & Promotions	Resident Days	171,230	9			15,202		12
13	21	Clerical and General Office	Resident Days	171,230	9	90,714		15,202	8,054	13
14	22	Employee Benefits & Payroll	Resident Days	171,230	9			15,202		14
15	23	Inservice Training & Education	Resident Days	171,230	9			15,202		15
16	24	Travel and Seminar	Resident Days	171,230	9			15,202		16
17	25	Other Admin. Staff Transport.	Resident Days	171,230	9			15,202		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	171,230	9			15,202		18
19	30	Depreciation	Resident Days	171,230	9			15,202		19
20	31	Amortization	Resident Days	171,230	9	55,441		15,202	4,922	20
21	32	Interest	Resident Days	171,230	9	254,149		15,202	22,564	21
22	33	Real Estate Taxes	Resident Days	171,230	9			15,202		22
23	34	Rent-Facility and Grounds	Resident Days	171,230	9			15,202		23
24	35	Rent-Equipment & Vehicles	Resident Days	171,230	9			15,202		24
25	TOTALS					$ 400,304	$		$ 35,540	25

Facility Name & ID Number Westside Rehab & Care Center # 0053488 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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Bank Leumi		X	Mortgage	Varies	1/1/15	$ 1,968,263	$ 1,901,828	12/31/2024	Varies	$ 97,650	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 1,968,263	$ 1,901,828			$ 97,650	9
	B. Non-Facility Related*											
10								Interest Income Offset			(38)	10
11								Home Office Allocation-PHB			22,564	11
12								Home Office Allocation-PHCM			237	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 22,763	14
15	TOTALS (line 9+line14)						$ 1,968,263	$ 1,901,828			$ 120,413	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 Westside Rehab & Care Center # 0053488 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.**	$	29,232	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.)	$	29,397	2
3. Under or (over) accrual (line 2 minus line 1).	$	165	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)	$	30,276	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**		185	
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.	$	30,626	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	28,582	8
	2012	27,402	9
	2013	26,015	10
	2014	26,183	11
	2015	29,397	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 Westside Rehab & Care Center COUNTY Franklin

FACILITY IDPH LICENSE NUMBER 0053488

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.	11-24-105-002	Long-Term Care Facility	$ 29,397.36	$ 29,397.36
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 29,397.36	$ 29,397.36

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 Westside Rehab & Care Center # 0053488 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 23,727 B. General Construction Type: Exterior Brick Frame Wood and Masonry 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: 188,185 2. Number of Years Over Which it is Being Amortized: 20

3. Current Period Amortization: 4,922 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	17,241	2009	$ 180,000	1
2					2
3	TOTALS	17,241		$ 180,000	3

Facility Name & ID Number Westside Rehab & Care Center # 0053488 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	96		2009	1979	$ 1,350,000	$	25	$ 54,000	$ 54,000	$ 405,000	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Roof Repair			2010	2,750		7	393	393	2,551	9
10	Call Cord Replacements			2014	10,481		15	699	699	1,748	10
11	Electrical Repairs			2016	3,400		7	243	243	243	11
12	Rooftop Heat Pump			2016	10,130		15	338	338	338	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						54,000			(54,000)		30
31	Building Booked					1,600			(1,600)		31
32	Building Improvement Booked										32
33											33
34	2016-Home Office Allocation-Building Improvements				6,712			161	161		34
35	2016-Home Office Allocation-Land Improvements				618			40	40		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 Westside Rehab & Care Center # 0053488 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)		$ 1,384,091	$ 55,600		$ 55,874	$ 274	$ 409,880	70

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

Facility Name & ID Number Westside Rehab & Care Center # 0053488 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	$ 322,872	$ 13,760	$ 32,288	$ 18,528	5-10 yrs.	$ 221,846	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Home Office Allocation			7,855	7,855			74
75	TOTALS	$ 322,872	$ 13,760	$ 40,143	$ 26,383		$ 221,846	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,886,963	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 69,360	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 96,017	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 26,657	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 631,726	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 Westside Rehab & Care Center # 0053488 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

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: $ 17,401 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	N/A				18
19					19
20					20
21	TOTAL		$	$	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.

Westside Rehab & Care Center
0053488
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	$ 12,546
Dishwasher	701
Copier	3,499
Home Office Allocation	655
	17,401

Facility Name & ID Number Westside Rehab & Care Center # 0053488 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 Westside Rehab & Care Center # 0053488 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		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	$	3,010	$ 45,157	$	3,010	$ 45,157	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		900	13,505		900	13,505	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		4,780	71,701	71	4,780	71,772	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				79,097		79,097	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			$	8,690	$ 130,363	$ 79,168	8,690	$ 209,531	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 Westside Rehab & Care Center **#** 0053488 **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	$ 562,815	$ 562,815	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 40,473)	601,348	601,348	3
4	Supply Inventory (priced at Cost)	6,808	6,808	4
5	Short-Term Investments			5
6	Prepaid Insurance	27,657	27,657	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Security Deposit	1,308	1,308	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,199,936	$ 1,199,936	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	180,000	180,000	13
14	Buildings, at Historical Cost	1,350,000	1,356,712	14
15	Leasehold Improvements, at Historical Cost	26,761	27,379	15
16	Equipment, at Historical Cost	322,872	322,872	16
17	Accumulated Depreciation (book methods)	(725,192)	(631,726)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,154,441	$ 1,255,237	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,354,377	$ 2,455,173	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 488,217	$ 488,217	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	66,827	66,827	30
31	Accrued Taxes Payable (excluding real estate taxes)	82,273	82,273	31
32	Accrued Real Estate Taxes(Sch.IX-B)	30,276	30,276	32
33	Accrued Interest Payable	8,188	8,188	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	215,928	215,928	36
37	Accrued Management Fees	559,664	559,664	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,451,373	$ 1,451,373	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,901,828	1,901,828	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Intercompany Loans	556,949	556,949	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,458,777	$ 2,458,777	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,910,150	$ 3,910,150	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,555,773)	$ (1,454,977)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,354,377	$ 2,455,173	48

***(See instructions.)**

Facility Name & ID Number Westside Rehab & Care Center # 0053488 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**	$ (1,485,557)	1
2	Restatements (describe):		2
3	**Prior Period Adjustment Made After Cost Reports Were Filed**	(7,520)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,493,077)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(62,696)	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)**	$ (62,696)	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)**	$ (1,555,773)	24 *

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

Facility Name & ID Number Westside Rehab & Care Center # 0053488 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	$ 2,053,643	1
2	Discounts and Allowances for all Levels	(191,745)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,861,898	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	242,101	6
7	Oxygen	112	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 242,213	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	3,390	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	117,576	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	14,754	20
21	Other Medical Services	9,909	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 145,629	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	38	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 38	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Transportation Revenue	9,732	28
28a	Miscellaneous Revenue	3,183	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 12,915	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,262,693	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	437,394	31
32	Health Care	990,071	32
33	General Administration	423,782	33
	B. Capital Expense		
34	Ownership	214,669	34
	C. Ancillary Expense		
35	Special Cost Centers	122,911	35
36	Provider Participation Fee	136,562	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,325,389	40
41	**Income before Income Taxes (line 30 minus line 40)****	(62,696)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (62,696)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,323,039	44
45	Private Pay - Net Inpatient Revenue	337,613	45
46	Medicare - Net Inpatient Revenue	197,027	46
47	Other-(specify) Insurance Net Inpatient Revenue	4,219	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 1,861,898	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 Westside Rehab & Care Center # 0053488 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	3,170	3,380	$ 74,403	$ 22.01	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,912	3,966	80,826	20.38	3
4	Licensed Practical Nurses	14,716	15,162	215,878	14.24	4
5	CNAs & Orderlies	22,485	22,644	268,614	11.86	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,913	2,069	24,125	11.66	9
10	Activity Assistants					10
11	Social Service Workers	1,606	1,703	20,958	12.31	11
12	Dietician					12
13	Food Service Supervisor	1,918	2,045	23,538	11.51	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,023	10,296	95,539	9.28	15
16	Dishwashers					16
17	Maintenance Workers	2,080	2,080	35,838	17.23	17
18	Housekeepers	8,933	9,292	84,617	9.11	18
19	Laundry	492	576	4,494	7.80	19
20	Administrator	2,080	2,080	65,000	31.25	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,847	1,924	28,483	14.80	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	2,080	2,080	41,470	19.94	32
33	Other(specify) Transportation	2,001	2,046	17,833	8.72	33
34	TOTAL (lines 1 - 33)	79,256	81,343	$ 1,081,616 *	$ 13.30	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	25	$ 1,428	L1, C3	35
36	Medical Director	Monthly	12,000	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,301	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)	25	$ 14,729		49

C. CONTRACT NURSES

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

Facility Name & ID Number Westside Rehab & Care Center # 0053488 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Chris Ely	Administrator	0	$ 65,000
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 65,000

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 191,100
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 191,100

C. Professional Services

Vendor/Payee	Type	Amount
Honkamp Kruger & Co.	Accounting Fees	$ 3,594
Mediacom	Computer Services	1,713
E-Health Data Solutions	Computer Services	2,941
Ability Network	Computer Services	102
Regions Bank	Legal Fees	80
Blue Cross Blue Shield	Medicare Fees	6,172
Consolidated Land Surveying	Surveying Fees	2,500
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 17,102

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 32,487
Unemployment Compensation Insurance	30,051
FICA Taxes	70,929
Employee Health Insurance	3,658
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	389
Home Office Allocation	20,355
TOTAL (agree to Schedule V, line 22, col.8)	$ 157,869

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

Description	Line #	Amount
		$
N/A		
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,393
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 27)	441
Patient Background Checks 31	442
Miscellaneous Licenses & Permits	333
Miscellaneous Dues & Subscriptions	1,150
Home Office Allocation	332
Less: Public Relations Expense	(150)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,941

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	10
Home Office Allocation	34
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 44

**See instructions.

Westside Rehab & Care Center
0053488
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)		17,102
Home Office Allocation		
Lucie, Scalf, and Bougher	Legal	35
Miscellaneous	Legal	13
Miller Hall and Triggs	Legal	61
Healthcare Resources International	Legal	306
Hunziker Law	Legal	73
Lexis Nexis	Legal	6
Illinois Secretary of State	Legal	44
Chicago Title Insurance	Legal	2,063
Bank Leumi	Legal	626
CliftonLarson Allen	Accountants	319
Ginoli & Co.	Accountants	2,722
Miscellaneous	Computer Services	40
Change Healthcare	Computer Services	6
PTC Select	Computer Services	4
Advanced Answers on Demand	Computer Services	2,800
Stratus Networks	Computer Services	285
Kemper Technology	Computer Services	188
AT&T	Computer Services	4
Ability Network	Computer Services	1,194
CIAN	Computer Services	142
Comcast	Computer Services	23
CCH	Computer Services	9
Charter Communications	Computer Services	28
Allscripts	Computer Services	416
ATS	Computer Services	188
Allpayer Exchange	Computer Services	9
Optimizer	Other Prof Fees	29
Ankura	Other Prof Fees	217
David Budde	Other Prof Fees	25
Bruner, Cooper, Zuck	Other Prof Fees	63
Marotta, Gund, Budd, Dzerda	Other Prof Fees	4,031
Professional Software and Services	Other Prof Fees	16
Hughes Valuation Services	Other Prof Fees	20
Alan Litwiller	Other Prof Fees	1
Total (agree to Schedule V, line 19, column 8)		33,108

Facility Name & ID Number Westside Rehab & Care Center # 0053488 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. **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. $ **9,761** 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. $ **136,562**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **3,390**

(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. $ **9,732**
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

RECONCILIATION REPORT **Westside Rehab & Care** **01:04 PM** **7/7/2017**

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	-49,977	equal to	-49,977	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	120,413	equal to	120,413	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	30,626	equal to	30,626	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & or	4,922	equal to	4,922	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	96,017	equal to	96,017	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	17,401	equal to	17,401	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	130,434	equal to	130,434	0	O.K.	Pg16 Z12+Z14..	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	79,168	equal to	79,168	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	437,394	equal to	437,394	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	990,071	equal to	990,071	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	423,782	equal to	423,782	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	214,669	equal to	214,669	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	122,911	equal to	122,911	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+I	N/A	38to41+43	4
Income Stat. Prov. Partic.	136,562	equal to	136,562	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	681,191	equal to	681,191	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	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	41,958	equal to	41,958	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	20,958	equal to	20,958	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	119,077	equal to	119,077	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	35,838	equal to	35,838	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	84,617	equal to	84,617	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	4,494	equal to	4,494	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	65,000	equal to	65,000	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	28,483	equal to	28,483	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	1,081,616	equal to	1,016,616	65,000	FAILED	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	1,428	< or = to	1,428	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	12,000	< or = to	12,000	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	1,301	< or = to	4,534	-3,233	O.K.	Pg20 X14..X16+	B. & C.	7to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to	241	-241	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	0	< or = to		0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	65,000	equal to	65,000	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	191,100	equal to	191,100	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	17,102	equal to	17,102	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	157,869	equal to	157,869	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	4,941	equal to	4,941	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	44	equal to	44	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	136,562	equal to	136,562	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	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	1,348	equal to	1,373	-25	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	-7,799	equal to	-7,799	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4	B.	14	8
Total loan balance	1,901,828	equal to	1,901,828	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27.	N/A	29+39-41	2
Real estate tax accrual	30,276	equal to	30,276	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	180,000	equal to	180,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	1,384,091	equal to	1,384,091	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	322,872	equal to	322,872	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	631,726	equal to	631,726	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	-1,555,773	equal to	-1,555,773	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	-62,696	equal to	-62,696	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	2,354,377	equal to	2,354,377	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 01:04:42 PM

HSA Number: 4 Name: **Westside Rehab & Care Center**

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 35,040 Occupancy: 15,202 Pct. of occupan 43.38%

ublic Aid Support Rate: $ ________

Genl Services S	244,026	Col 1, Line 8 ---Audit Adj:	
Genl Admin Sal	28,483	Col 1, Line 28 ---Audit Adj:	
Total Salary Wa	1,016,616	Col 1, Line 44 ---Audit Adj:	
Employee Bene	157,869	Col 8, Line 22 ---Audit Adj:	
Total General S	439,126	Col 8, Line 8 ---Audit Adj:	
Total General A	373,957	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)	$244,026
Divided by Total Wages (Column 1, Line 44)	$1,016,616
General service wages as percent of total wages	24.0038%
Employee Benefits (Column 10, Line 22)	$157,869
Allocation of Employee Benefits to General Services Costs	$37,895
Plus Total General Services (Column 10, Line 8)	$439,126
New Total General Services Cost	$477,021

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).	$28,483
Divided by Total Wages (Column 1, Line 45)	$1,016,616
General administration wages as a percent of total wages	2.8017%
Employee Benefits (Column 10, Line 22)	$157,869
Allocation of Employee Benefits to General Admin. Costs	$4,423
Plus Total General Administration (Column 10, Line 28)	$373,957
Minus Total Fringe (Column 10, Line 22)	$157,869
New Total General Administration Cost	$220,511

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)	$477,021	
General Services Multiplier (Step II-B)	1	
Updated General Services Cost		$477,021

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)	$220,511	
General Administration Multiplier (Step II-B)	1	
Updated General Services Cost		$220,511
3 Total Updated Support Costs (1 + 2)		$697,532

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 $33.22

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)	$697,532
Total Patient Days (Cost Report)	15,202
Support Costs per Diem	$45.88

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	35,040
Multiplied by	0.93
	32,587
Minus total Patient Days	15,202
	17,385
One-third of difference	5,795
Plus Total Patient Days	15,202
Adjusted Occupancy	20,997
Total Support Costs (Step II, C, 3, above)	$697,532
Divided by Adjusted Occupany	20997
Support Costs Per Diem	$33.22

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	$33.22
Difference	$14.22
Multiply the Difference by	0.5
One-Half of the Difference	$7.11
Plus Support Costs Per Diem	$33.22
Support Rate if costs are between 35th and 75th percentile	40.33

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	$33.22
Difference	$14.22
Multiply the Difference by	0.5
One-Half of the Difference	$7.11
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	$3.795
Plus Support Costs Per Diem	$33.22
Support Rate if support costs less than 35th percentile	$37.02

D. YOUR FINAL TOTAL SUPPORT RATE from A, B, or C above **$37.02**

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	119,077	7,688	1,428	128,193	0	128,193	3,123	131,316
2. Food Purchase	0	94,294	0	94,294	0	94,294	-3,333	90,961
3. Housekeeping	84,617	10,500	0	95,117	0	95,117	55	95,172
4. Laundry	4,494	6,055	10	10,559	0	10,559	0	10,559
5. Heat and Other Utilities	0	0	52,348	52,348	0	52,348	182	52,530
6. Maintenance	35,838	3,822	17,223	56,883	0	56,883	1,705	58,588
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	244,026	122,359	71,009	437,394	0	437,394	1,732	439,126
9. Medical Director	0	0	12,000	12,000	0	12,000	0	12,000
10. Nursing & Medical Records	681,191	98,517	4,534	784,242	0	784,242	-3,048	781,194
10a. Therapy	0	71	130,363	130,434	0	130,434	0	130,434
11. Activities	41,958	233	241	42,432	0	42,432	-9,732	32,700
12. Social Services	20,958	5	0	20,963	0	20,963	0	20,963
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	744,107	98,826	147,138	990,071	0	990,071	-12,780	977,291
17. Administrative	0	0	191,100	191,100	0	191,100	-126,100	65,000
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	17,102	17,102	0	17,102	16,006	33,108
20. Fees, Subscriptions & Promotion	0	0	4,759	4,759	0	4,759	182	4,941
21. Clerical & General Office	28,483	1,676	9,742	39,901	0	39,901	36,361	76,262
22. Employee Benefits & Payroll	0	0	137,514	137,514	0	137,514	20,355	157,869
23. Inservice Training & Education	0	0	0	0	0	0	70	70
24. Travel and Seminar	0	0	10	10	0	10	34	44
25. Other Admin. Staff Trans	0	0	4,263	4,263	0	4,263	2,864	7,127
26. Insurance-Prop.Liab.Malpractice	0	0	29,133	29,133	0	29,133	403	29,536
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	28,483	1,676	393,623	423,782	0	423,782	-49,825	373,957
29. Total General Administrative	1,016,616	222,861	611,770	1,851,247	0	1,851,247	-60,873	#######
30. Depreciation	0	0	69,832	69,832	0	69,832	26,185	96,017
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	4,922	4,922
32. Interest	0	0	97,650	97,650	0	97,650	22,763	120,413
33. Real Estate	0	0	30,441	30,441	0	30,441	185	30,626
34. Rent - Facility & Grounds	0	0	0	0	0	0	0	0
35. Rent - Equipment & Vehicles	0	0	16,746	16,746	0	16,746	655	17,401
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	214,669	214,669	0	214,669	54,710	269,379
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	79,097	0	79,097	0	79,097	0	79,097
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	136,562	136,562	0	136,562	0	136,562
43. Other (specify):*	0	115	43,699	43,814	0	43,814	-43,814	0
44. Total Special Cost Ce	0	79,212	180,261	259,473	0	259,473	-43,814	215,659
45. Grand Total	1,016,616	302,073	1,006,700	2,325,389	0	2,325,389	-49,977	#######

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	562,815	562,815
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	601,348	601,348
4. Supply Inventory	6,808	6,808
5. Short-Term Investments	0	0
6. Prepaid Insurance	27,657	27,657
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	1,308	1,308
10. Total current assets	1,199,936	1,199,936
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	180,000	180,000
14. Buildings, at Historical Cost	1,350,000	1,356,712
15. Leasehold Improvements, Historical Cost	26,761	27,379
16. Equipment, at Historical Cost	322,872	322,872
17. Accumulated Depreciation (book methods)	-725,192	-631,726
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	0
24. Total Long-Term Assets	1,154,441	1,255,237
25. Total Assets	2,354,377	2,455,173
CURRENT LIABILITIES		
26. Accounts Payable	488,217	488,217
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	66,827	66,827
31. Accrued Taxes Payable	82,273	82,273
32. Accrued Real Estate Taxes	30,276	30,276
33. Accrued Interest Payable	8,188	8,188
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	215,928	215,928
37. Other Current Liabilities (specify):	559,664	559,664
38. Total Current Liabilities	1,451,373	1,451,373
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	1,901,828	1,901,828
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	556,949	556,949
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	2,458,777	2,458,777
46.Total Liabilities	3,910,150	3,910,150
47.Total Equity	########	-1,454,977
48.Total Liabilities and Equity	2,354,377	2,455,173

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	2,053,643
2. Discounts and Allowances for all Levels	-191,745
Subtotal - Inpatient Care	1,861,898
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	242,101
7. Oxygen	112
Subtotal - Anciliary Revenue	242,213
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	3,390
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	117,576
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiologyand X-Ray	14,754
21. Other Medical Services	9,909
22. Laundry	0
Subtotal - Other Operating Revenue	145,629
24. Contributions	0
25. Interest and Other Investments Income	38
Subtotal - Non-Operating Revenue	38
27. Other Revenue (specify):	9,732
28. Other Revenue (specify):	3,183
Subtotal - Other Revenue	12,915
30. Total Revenue	2,262,693
31. General Services	340,339
32. Health Care	814,665
33. General Administration	332,882
34. Ownership	181,317
35. Special Cost Centers	207,771
35. Provider Participation Fee	110,290
37. Other	0
40. Total Expenses	1,987,264
41. Income Before Income Taxes	275,429
42. Income Taxes	0
43. Net Income or Loss for the Year	275,429