

Facility Name & ID Number Effingham Rehabilitation & Health Care Center

0054387 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	62	Skilled (SNF)	62	22,630	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	62	TOTALS	62	22,630	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	10,911	3,630	1,699	16,240	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,911	3,630	1,699	16,240	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.76%

D. How many bed reserve days during this year were paid by the Department? None (Do not include bed reserve 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 NO

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

I. On what date did you start providing long term care at this location?
Date started 5/1/2005

J. Was the facility purchased or leased after January 1, 1978?
YES Date 5/1/2005 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 62 and days of care provided 1,556

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number Effingham Rehabilitation & Health Care Cen # 0054387 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	122,426	10,434		132,860		132,860	3,646	136,506		1
2	Food Purchase		105,781		105,781		105,781	(1,139)	104,642		2
3	Housekeeping	73,081	14,669		87,750		87,750	55	87,805		3
4	Laundry	36,487	6,112		42,599		42,599		42,599		4
5	Heat and Other Utilities			61,295	61,295		61,295	192	61,487		5
6	Maintenance	36,714	3,768	12,690	53,172		53,172	1,723	54,895		6
7	Other (specify):* <u>Home Office Ben. Allocation</u>										7
8	TOTAL General Services	268,708	140,764	73,985	483,457		483,457	4,477	487,934		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	753,050	76,058	11,438	840,546		840,546	(676)	839,870		10
10a	Therapy		17	249,375	249,392		249,392		249,392		10a
11	Activities	55,023	37	682	55,742		55,742	(6,941)	48,801		11
12	Social Services	26,551			26,551		26,551		26,551		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Office Ben. Allocation</u>										15
16	TOTAL Health Care and Programs	834,624	76,112	267,495	1,178,231		1,178,231	(7,617)	1,170,614		16
	C. General Administration										
17	Administrative			188,600	188,600		188,600	(141,667)	46,933		17
18	Directors Fees										18
19	Professional Services			7,444	7,444		7,444	11,417	18,861		19
20	Dues, Fees, Subscriptions & Promotions			5,912	5,912		5,912	85	5,997		20
21	Clerical & General Office Expenses	31,834	3,579	9,108	44,521		44,521	39,238	83,759		21
22	Employee Benefits & Payroll Taxes			141,350	141,350		141,350	17,649	158,999		22
23	Inservice Training & Education			60	60		60	109	169		23
24	Travel and Seminar							54	54		24
25	Other Admin. Staff Transportation			6,699	6,699		6,699	2,613	9,312		25
26	Insurance-Prop.Liab.Malpractice			19,714	19,714		19,714	692	20,406		26
27	Other (specify):* <u>Home Office Ben. Allocation</u>										27
28	TOTAL General Administration	31,834	3,579	378,887	414,300		414,300	(69,810)	344,490		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,135,166	220,455	720,367	2,075,988		2,075,988	(72,950)	2,003,038		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

Effingham Rehabilitation & Health Care Center

#0054387

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			3,072	3,072		3,072	48,586	51,658			30
31	Amortization of Pre-Op. & Org.							3,875	3,875			31
32	Interest							67,323	67,323			32
33	Real Estate Taxes			38,072	38,072		38,072	209	38,281			33
34	Rent-Facility & Grounds			118,073	118,073		118,073	(118,073)				34
35	Rent-Equipment & Vehicles			20,175	20,175		20,175	1,108	21,283			35
36	Other (specify):*											36
37	TOTAL Ownership			179,392	179,392		179,392	3,028	182,420			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		41,351		41,351		41,351		41,351			39
40	Barber and Beauty Shops			8	8		8		8			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			122,555	122,555		122,555		122,555			42
43	Other (specify):*		345	67,698	68,043		68,043	(68,043)				43
44	TOTAL Special Cost Centers		41,696	190,261	231,957		231,957	(68,043)	163,914			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,135,166	262,151	1,090,020	2,487,337		2,487,337	(137,965)	2,349,372			45

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

Effingham Rehabilitation & Health Care Center

ID# 0054387

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Labs-Part A	\$ (2,719)	43	1
2	X-Rays-Part A	(1,504)	43	2
3	Offset Miscellaneous Nursing Supplies Revenue	(727)	10	3
4	Offset Transportation Revenue	(6,941)	11	4
5	Disallowed Special Events	(280)	43	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
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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	(12,171)		49

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	1 Dietary	\$	Petersen Health Care Management, Inc.	100.00%	\$ 3,646	\$ 3,646	1
2	V	2 Food		Petersen Health Care Management, Inc.	100.00%	16	16	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%	192	192	4
5	V	6 Maintenance		Petersen Health Care Management, Inc.	100.00%	1,723	1,723	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%	51	51	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	188,600	Petersen Health Care Management, Inc.	100.00%	46,933	(141,667)	11
12	V	19 Professional Services		Petersen Health Care Management, Inc.	100.00%	11,417	11,417	12
13	V							13
14	Total		\$ 188,600			\$ 64,033	\$ * (124,567)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	20 Dues, Fees, Subs & Promotions	\$	Petersen Health Care Management, Inc.	100.00%	\$ 85	\$	85	15
16	V	21 Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	39,238		39,238	16
17	V	22 Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	17,649		17,649	17
18	V	23 Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	109		109	18
19	V	24 Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	54		54	19
20	V	25 Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	2,613		2,613	20
21	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	692		692	21
22	V	30 Depreciation		Petersen Health Care Management, Inc.	100.00%	9,344		9,344	22
23	V	31 Amortization		Petersen Health Care Management, Inc.	100.00%	84		84	23
24	V	32 Interest		Petersen Health Care Management, Inc.	100.00%	304		304	24
25	V	33 Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	209		209	25
26	V	35 Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	1,108		1,108	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		\$			\$ 71,489	\$ *	71,489	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	19 Professional Services	\$	Petersen VII, LLC	100.00%	\$	\$
16	V	26 Insurance-Property		Petersen VII, LLC	100.00%		
17	V	26 Insurance-MIP		Petersen VII, LLC	100.00%		
18	V	30 Depreciation		Petersen VII, LLC	100.00%	39,951	39,951
19	V	31 Amortization		Petersen VII, LLC	100.00%	3,791	3,791
20	V	32 Interest		Petersen VII, LLC	100.00%	67,020	67,020
21	V	33 Real Estate Taxes		Petersen VII, LLC	100.00%		
22	V	34 Rent-Income and Grounds	118,073	Petersen VII, LLC	100.00%		(118,073)
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 118,073			\$ 110,762	\$ * (7,311)

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

Facility Name & ID Number

Effingham Rehabilitation & Health Care Center

0054387

Report Period Beginning:

1/1/2017

Ending: 12/31/2017

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Aledo Health Care Center	Aledo	Petersen Companies, I	Peoria	Mgmt/Bookkeeping	1
2			Arcola Health Care Center	Arcola	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	2
3			Aspen Rehab & Health Care	Silvis	Petersen Health Care,	Peoria	Mgmt/Bookkeeping	3
4			Batavia Rehab & Health Care Center	Batavia	Petersen Health Enter	Peoria	Mgmt/Bookkeeping	4
5			Bement Health Care Center	Bement	Petersen Health Opera	Peoria	Mgmt/Bookkeeping	5
6			Benton Rehab & Health Care Center	Benton	Petersen Health System	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	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 Busine	Peoria	Mgmt/Bookkeeping	11
12			Countryview Terrace	Louisville	Petersen Health Care	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care	Peoria	Lessor	13
14			Decatur Rehab & Health Care Center	Decatur	Midwest Health Opera	Peoria	Mgmt/Bookkeeping	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Health Prope	Peoria	Mgmt/Bookkeeping	15
16			Eastview Terrace	Sullivan	Petersen Roseville, LL	Roseville	Lessor	16
17			El Paso Health Care Center	El Paso	Petersen Health Juncti	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Petersen Health Qualit	Peoria	Mgmt/Bookkeeping	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Health and W	Peoria	Mgmt/Bookkeeping	19
20			Flanagan Rehab & Health Care Center	Flanagan	Petersen 24, LLC	Peoria	Hospitality	20
21			Flora Gardens Care Center	Flora				21
22			Flora Health Care Center	Flora				22
23			Fondulac Rehab & Health Care Center	East Peoria				23
24			Havana Health Care Center	Havana				24
25			Illini Heritage Rehab & Health Care	Champaign				25
26			Jonesboro Rehab & Health Care Center	Jonesboro				26
27			Kewanee Care Home	Kewanee				27
28			LaHarpe Davier Health Care Center	LaHarpe				28
29			Lebanon Care Center	Lebanon				29
30			Marigold Rehab & Health Care Center	Galesburg				30

Facility Name & ID Number

Effingham Rehabilitation & Health Care Center

0054387

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

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

Effingham Rehabilitation & Health Care Center

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Report Period Beginning:

1/1/2017

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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 Effingham Rehabilitation & Health Care Ce # 0054387 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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											3
4	N/A										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 Effingham Rehabilitation & Health Care Center # 0054387 Report Period Beginning: 1/1/2017 Ending: 2/31/2017

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization Petersen Health Care 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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,451,714	75	\$ 325,901	\$ 376,129	16,240	\$ 3,646	1
2	2	Food	Resident Days	1,451,714	75	1,404	0	16,240	16	2
3	3	Housekeeping	Resident Days	1,451,714	75	4,904	2,743	16,240	55	3
4	5	Utilities	Resident Days	1,451,714	75	17,131	0	16,240	192	4
5	6	Maintenance	Resident Days	1,451,714	75	153,997	146,594	16,240	1,723	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,451,714	75	0	0	16,240	0	6
7	9	Medical Director	Resident Days	1,451,714	75	0	0	16,240	0	7
8	10	Nursing and Medical Records	Resident Days	1,451,714	75	4,528	1,833,909	16,240	51	8
9	10A	Therapy	Resident Days	1,451,714	75	0	0	16,240	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,451,714	75	0	0	16,240	0	10
11	17	Administrative	Resident Days	1,451,714	75	4,871,788	5,558,349	16,240	46,933	11
12	19	Professional Services	Resident Days	1,451,714	75	1,020,623	0	16,240	11,417	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,451,714	75	7,613	0	16,240	85	13
14	21	Clerical and General Office	Resident Days	1,451,714	75	3,507,569	3,782,761	16,240	39,238	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,451,714	75	1,577,706	0	16,240	17,649	15
16	23	Inservice Training & Education	Resident Days	1,451,714	75	9,731	0	16,240	109	16
17	24	Travel and Seminar	Resident Days	1,451,714	75	4,833	0	16,240	54	17
18	25	Other Admin. Staff Transport.	Resident Days	1,451,714	75	233,560	0	16,240	2,613	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,451,714	75	61,886	0	16,240	692	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,451,714	75	835,302	0	16,240	9,344	20
21	30	Depreciation	Resident Days	1,451,714	75	7,526	0	16,240	84	21
22	32	Interest	Resident Days	1,451,714	75	27,155	0	16,240	304	22
23	33	Real Estate Taxes	Resident Days	1,451,714	75	18,716	0	16,240	209	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,451,714	75	99,030	0	16,240	1,108	24
25	TOTALS					\$ 12,790,903	\$ 11,700,485		\$ 135,522	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	Bank Leumi		X	Mortgage	Varies	5/20/16	\$ 130,000	\$ 80,550	5/19/41	Varies	\$ 67,020	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6												6						
7												7						
8												8						
9	TOTAL Facility Related						\$ 130,000	\$ 80,550			\$ 67,020	9						
B. Non-Facility Related*																		
10									Interest Income Offset		(1)	10						
11									Home Office Allocation-PHCM		304	11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ 303	14						
15	TOTALS (line 9+line14)						\$ 130,000	\$ 80,550			\$ 67,323	15						

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

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

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

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2016 report.		\$	<u>37,788</u>	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.)		\$	<u>37,513</u>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>(275)</u>	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>38,347</u>	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. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	Home Office Allocation	\$	<u>209</u>	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<u>38,281</u>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2012	<u>33,359</u>	8
	2013	<u>34,092</u>	9
	2014	<u>34,758</u>	10
	2015	<u>36,683</u>	11
	2016	<u>37,513</u>	12

Accrual based on prior year tax bill.

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2016	\$	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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 21,644 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

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

1. Total Amount Incurred: 126,071 2. Number of Years Over Which it is Being Amortized: 5
3. Current Period Amortization: 3,875 4. Dates Incurred: 2015-2016

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	176,400	2005	\$ 50,000	1
2					2
3	TOTALS	176,400		\$ 50,000	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	62	2005	1998	\$ 718,400	\$	30	\$ 23,947	\$ 34,053	\$ 303,328
5									
6									
7									
8									
Improvement Type**									
9	Fence		2007	19,070		15	1,271	1,271	12,075
10	Landscaping		2007	30,800		15	2,053	2,053	19,504
11	Remodeling of North & South Nurse's Station		2009	48,047		15	3,204	3,204	24,030
12	Parking Lot Repair		2010	2,506		7	358	358	2,327
13	Sprinkler System Replacement		2013	82,460		25	3,298	3,298	14,841
14	Sewer Line Repair		2013	2,625		7	375	375	1,313
15	Tiling in Common Areas		2015	8,233		10	823	823	2,118
16	A/C Repair		2016	3,195		7	456	456	684
17	Roof Replacement		2017	53,675		25	1,074	1,074	1,074
18	HVAC Rooftop Unit		2017	5,886		15	196	196	196
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30	Land Improvements Booked				3,485			(3,485)	
31	Building Booked				23,947			(23,947)	
32	Building Improvement Booked				12,059			(12,059)	
33									
34	2017-Home Office Allocation-Building Improvements			7,428			178	178	
35	2017-Home Office Allocation-Land Improvements			684			44	44	
36									

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	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)	\$ 983,009	\$ 39,491		\$ 37,277	\$ 7,892	\$ 381,490	70

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

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	\$ 53,527	\$ 3,259	\$ 5,025	\$ 1,766	5-10 yrs.	\$ 35,471	71
72	Current Year Purchases	3,275	273	234	(39)	7 yrs.	234	72
73	Fully Depreciated Assets	212,002					212,002	73
74	Home Office Allocation			9,122	9,122			74
75	TOTALS	\$ 268,804	\$ 3,532	\$ 14,381	\$ 10,849		\$ 247,707	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)	\$ 1,301,813	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 43,023	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 51,658	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 8,635	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 629,197	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					88
89	N/A				89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

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.	_____ /2018	\$ _____
13.	_____ /2019	\$ _____
14.	_____ /2020	\$ _____

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: \$ 16,658 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	<u>Facility</u>	<u>2006 Ford E250</u>	\$ <u>578</u>	\$ <u>4,625</u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u>578.17</u>	\$ <u>4,625</u>	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.

**Effingham Rehabilitation & Health Care Center
0054387**

Period Beginning 1/1/2017
Period End 12/31/2017

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$	11,900
Dishwasher		701
Copier		2,949
Home Office Allocation		1,108
		<u>16,658</u>

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	6,703	\$ 100,540	\$	6,703	\$ 100,540	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2,188	32,819		2,188	32,819	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		7,734	116,016	17	7,734	116,033	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 prescripts				41,351		41,351	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			\$	16,625	\$ 249,375	\$ 41,368	16,625	\$ 290,743	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 Effingham Rehabilitation & Health Care Center

0054387

Report Period Beginning: 1/1/2017

Ending:

12/31/2017

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2017

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (197,222)	\$ (197,222)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 97,799)	1,201,683	1,201,683	3
4	Supply Inventory (priced at Cost)	9,725	9,725	4
5	Short-Term Investments			5
6	Prepaid Insurance	13,686	13,686	6
7	Other Prepaid Expenses	537	537	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,028,409	\$ 1,028,409	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		50,000	13
14	Buildings, at Historical Cost		725,828	14
15	Leasehold Improvements, at Historical Cost	62,755	257,181	15
16	Equipment, at Historical Cost	3,275	268,804	16
17	Accumulated Depreciation (book methods)	(3,263)	(629,197)	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): <u>Intercompany Loans</u>	514,706		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 577,473	\$ 672,616	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,605,882	\$ 1,701,025	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 428,488	\$ 428,488	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	60,881	60,881	30
31	Accrued Taxes Payable (excluding real estate taxes)	76,299	76,299	31
32	Accrued Real Estate Taxes(Sch.IX-B)	38,347	38,347	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37	<u>Accrued Management Fees</u>	386,363	386,363	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 990,378	\$ 990,378	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		80,550	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Intercompany Loans</u>	125,103	125,103	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 125,103	\$ 205,653	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,115,481	\$ 1,196,031	46
47	TOTAL EQUITY(page 18, line 24)	\$ 490,401	\$ 504,994	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,605,882	\$ 1,701,025	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 280,035	1
2	Restatements (describe):		2
3	Adjustments Made After Cost Report Was Filed	6,089	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 286,124	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	204,277	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)	\$ 204,277	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)	\$ 490,401	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Effingham Rehabilitation & Health Care Center

0054387

Report Period Beginning: 1/1/2017

Ending:

12/31/2017

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,315,701	1
2	Discounts and Allowances for all Levels	(199,184)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,116,517	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	463,976	6
7	Oxygen	3,073	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 467,049	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,155	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	82,733	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	4,125	20
21	Other Medical Services	12,366	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 100,379	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Transportation Revenue</u>	6,941	28
28a	<u>Miscellaneous Revenue</u>	727	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 7,668	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,691,614	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	483,457	31
32	Health Care	1,178,231	32
33	General Administration	414,300	33
B. Capital Expense			
34	Ownership	179,392	34
C. Ancillary Expense			
35	Special Cost Centers	109,402	35
36	Provider Participation Fee	122,555	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,487,337	40
41	Income before Income Taxes (line 30 minus line 40)**	204,277	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 204,277	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 1,297,139	44
45	Private Pay - Net Inpatient Revenue	513,417	45
46	Medicare - Net Inpatient Revenue	304,727	46
47	Other-(specify) <u>Insurance Net Inpatient Revenue</u>	1,234	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,116,517	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 Effingham Rehabilitation & Health Care Center

0054387

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,789	1,789	\$ 52,549	\$ 29.37	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,755	9,037	239,848	26.54	3
4	Licensed Practical Nurses	5,106	5,194	98,816	19.03	4
5	CNAs & Orderlies	24,856	25,808	290,715	11.26	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,839	1,948	24,012	12.33	8
9	Activity Director	2,069	2,124	29,886	14.07	9
10	Activity Assistants					10
11	Social Service Workers	1,980	2,068	26,551	12.84	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	34,293	16.49	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,116	9,282	88,133	9.50	15
16	Dishwashers					16
17	Maintenance Workers	1,915	2,075	36,714	17.69	17
18	Housekeepers	6,901	7,320	73,081	9.98	18
19	Laundry	3,084	3,161	36,487	11.54	19
20	Administrator	2,080	2,080	46,933	22.56	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,080	2,080	31,834	15.30	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	1,703	1,703	47,110	27.66	32
33	Other(specify) <u>Transportation</u>	1,931	2,054	25,137	12.24	33
34	TOTAL (lines 1 - 33)	77,284	79,803	\$ 1,182,099 *	\$ 14.81	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant			35	
36	Medical Director	Monthly	6,000	L9,C3	36
37	Medical Records Consultant			37	
38	Nurse Consultant			38	
39	Pharmacist Consultant	Monthly	4,439	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)		\$ 10,439		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	8	\$ 288	L10, C3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	8	\$ 288		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Shirley Acree	Administrator	0	\$ 3,581	Workers' Compensation Insurance	\$ 22,295	IDPH License Fee	\$ 2,808	
Shannon May	Administrator	0	25,759	Unemployment Compensation Insurance	32,193	Advertising: Employee Recruitment	660	
Jessica Warren	Administrator	0	17,593	FICA Taxes	84,503	Health Care Worker Background Check (Indicate # of checks performed <u>141</u>)	965	
				Employee Health Insurance	1,916	Patient Background Checks		
				Employee Meals		Miscellaneous Licenses & Permits	527	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Dues & Subscriptions	952	
				Employee Relations	443	Home Office Allocation	85	
				Home Office Allocation	17,649			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 46,933			Less: Public Relations Expense	()	
B. Administrative - Other						Non-allowable advertising	()	
Description			Amount			Yellow page advertising	()	
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 188,600					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 188,600	TOTAL (agree to Schedule V, line 22, col.8)	\$ 158,999	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 5,997	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
ProTitle USA	Legal Fees		\$ 192				Out-of-State Travel	\$
Mediacom	Computer Services		1,797					
Allscripts	Data Services		888					
Ability Network	Computer Services		4,567	N/A			In-State Travel	
							Seminar Expense	
							Home Office Allocation	54
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 7,444	TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)	\$ 54

* Attach copy of IMRF notifications

**See instructions.

Effingham Rehabilitation & Health Care Center**0054387****Period Beginning****1/1/2017****Period End****12/31/2017****Schedule 21A****XIX. SUPPORT SCHEDULE****C. Professional Services**

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		7,444
Home Office Allocation		
MusilloUnkenholt, LLC	Legal	130
Arnstein & Lehr	Legal	877
SB2	Legal	551
Miscellaneous	Legal	10
Miller Hall and Triggs	Legal	139
Smith Amundsen	Legal	54
Healthcare Resources International	Legal	97
Hunziker Law	Legal	1
Lexis Nexis	Legal	6
Baker Tilly Virchow Krause	Legal	489
CliftonLarsonAllen	Accounting	1567
Ginoli & Co.	Accounting	308
Baker Tilly Virchow Krause	Accounting	98
Miscellaneous	Computer Services	74
Change Healthcare	Computer Services	6
360 Networks	Computer Services	30
Matrix Care	Computer Services	2732
Stratus Networks	Computer Services	326
Kemper Technology	Computer Services	185
AT&T	Computer Services	5
Ability Network	Computer Services	201
CIAN	Computer Services	227
Comcast	Computer Services	13
CCH	Computer Services	11
Charter Communications	Computer Services	23
Allscripts	Computer Services	202
ATS	Computer Services	208
Citrix Systems	Computer Services	19
Optimizer	Other Prof Fees	37
Ankura	Other Prof Fees	588
David Budde	Other Prof Fees	27
Sargent Consulting	Other Prof Fees	1635
Alix Partners	Other Prof Fees	398
Demonica Kemper	Other Prof Fees	24
Brad Barkley	Other Prof Fees	96
MPAC Healthcare	Other Prof Fees	14
Higgs Appraisal	Other Prof Fees	7
Alan Litwiller	Other Prof Fees	2
Total (agree to Schedule V, line 19, column 8)		<u>18,861</u>

Facility Name & ID Number Effingham Rehabilitation & Health Care Center# 0054387Report Period Beginning: 1/1/2017Ending: 12/31/2017**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-\$952
- (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. \$ 12,864 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. \$ 122,555
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. \$ 1,155
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 3,960
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? Yes**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 2,981
- (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