

Facility Name & ID Number Enfield Rehabilitation & Health Care Center

0053157 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	23	Skilled (SNF)	23	8,395	1
2		Skilled Pediatric (SNF/PED)			2
3	24	Intermediate (ICF)	24	8,760	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	47	TOTALS	47	17,155	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		1,315	471	1,786	8
9	SNF/PED					9
10	ICF	7,805			7,805	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,805	1,315	471	9,591	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 55.91%

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 10/1/2005

J. Was the facility purchased or leased after January 1, 1978?
YES Date 10/1/2005 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 23 and days of care provided 420

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 Enfield Rehabilitation & Health Care Center # 0053157 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	86,491	6,498		92,989		92,989	2,153	95,142		1
2	Food Purchase		56,627		56,627		56,627	(1,188)	55,439		2
3	Housekeeping	50,224	12,770		62,994		62,994	32	63,026		3
4	Laundry		3,300		3,300		3,300		3,300		4
5	Heat and Other Utilities			32,191	32,191		32,191	113	32,304		5
6	Maintenance	29,543	1,077	14,828	45,448		45,448	1,017	46,465		6
7	Other (specify):* <u>Home Office Ben. Allocation</u>										7
8	TOTAL General Services	166,258	80,272	47,019	293,549		293,549	2,127	295,676		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	457,942	56,017	4,802	518,761		518,761	(2,515)	516,246		10
10a	Therapy			67,000	67,000		67,000		67,000		10a
11	Activities	32,247			32,247		32,247	(10,806)	21,441		11
12	Social Services	28,222			28,222		28,222		28,222		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	518,411	56,017	77,802	652,230		652,230	(13,321)	638,909		16
	C. General Administration										
17	Administrative			150,700	150,700		150,700	(83,950)	66,750		17
18	Directors Fees										18
19	Professional Services			106,040	106,040		106,040	(65,519)	40,521		19
20	Dues, Fees, Subscriptions & Promotions			1,342	1,342		1,342	50	1,392		20
21	Clerical & General Office Expenses	7,297	327	5,011	12,635		12,635	23,111	35,746		21
22	Employee Benefits & Payroll Taxes			82,630	82,630		82,630	10,423	93,053		22
23	Inservice Training & Education							64	64		23
24	Travel and Seminar							32	32		24
25	Other Admin. Staff Transportation			4,864	4,864		4,864	1,543	6,407		25
26	Insurance-Prop.Liab.Malpractice			15,585	15,585		15,585	409	15,994		26
27	Other (specify):* <u>Home Office Ben. Allocation</u>										27
28	TOTAL General Administration	7,297	327	366,172	373,796		373,796	(113,837)	259,959		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	691,966	136,616	490,993	1,319,575		1,319,575	(125,031)	1,194,544		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

Enfield Rehabilitation & Health Care Center

#0053157

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			26,037	26,037		26,037	(615)	25,422			30
31	Amortization of Pre-Op. & Org.							3,279	3,279			31
32	Interest							21,884	21,884			32
33	Real Estate Taxes			7,508	7,508		7,508	124	7,632			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			13,990	13,990		13,990	654	14,644			35
36	Other (specify):*											36
37	TOTAL Ownership			47,535	47,535		47,535	25,326	72,861			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		10,320		10,320		10,320		10,320			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			81,476	81,476		81,476		81,476			42
43	Other (specify):*		8	27,277	27,285		27,285	(27,285)				43
44	TOTAL Special Cost Centers		10,328	108,753	119,081		119,081	(27,285)	91,796			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	691,966	146,944	647,281	1,486,191		1,486,191	(126,990)	1,359,201			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,197)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,285)	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	(6,134)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(7)	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	(4,115)	43		18
19	Entertainment				19
20	Contributions	(25)	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	(15,000)	43		24
25	Fund Raising, Advertising and Promotional	(732)	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	(116,534)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (148,029)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	21,039	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 21,039		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (126,990)		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY

48		49		50		51		52	
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Enfield Rehabilitation & Health Care Center

ID# 0053157

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Offset Miscellaneous Nursing Supplies Revenue	\$ (2,545)	10	1
2	Offset Transportation Revenue	(10,806)	11	2
3	Disallow Special events	(223)	43	3
4	X-Rays Part A	(1,930)	43	4
5	Labs Part A	(968)	43	5
6	Offset Miscellaneous Office Supplies Revenue	(62)	21	6
7	Disallowed Legal Settlement	(100,000)	19	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
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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	(116,534)		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:	
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)	
1	V	1 Dietary	\$	Petersen Health Care Management, Inc.	100.00%	\$ 2,153	\$ 2,153	1
2	V	2 Food		Petersen Health Care Management, Inc.	100.00%	9	9	2
3	V	3 Housekeeping		Petersen Health Care Management, Inc.	100.00%	32	32	3
4	V	5 Utilities		Petersen Health Care Management, Inc.	100.00%	113	113	4
5	V	6 Maintenance		Petersen Health Care Management, Inc.	100.00%	1,017	1,017	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%	30	30	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	150,700	Petersen Health Care Management, Inc.	100.00%	66,750	(83,950)	11
12	V	19 Professional Services		Petersen Health Care Management, Inc.	100.00%	6,743	6,743	12
13	V							13
14	Total		\$ 150,700			\$ 76,847	\$ * (73,853)	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%	\$ 50	\$	50	15
16	V	21 Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	23,173		23,173	16
17	V	22 Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	10,423		10,423	17
18	V	23 Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	64		64	18
19	V	24 Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	32		32	19
20	V	25 Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	1,543		1,543	20
21	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	409		409	21
22	V	30 Depreciation		Petersen Health Care Management, Inc.	100.00%	5,519		5,519	22
23	V	31 Amortization		Petersen Health Care Management, Inc.	100.00%	50		50	23
24	V	32 Interest		Petersen Health Care Management, Inc.	100.00%	179		179	24
25	V	33 Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	124		124	25
26	V	35 Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	654		654	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		\$			\$ 42,220	\$ *	42,220	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1 Dietary	\$	Petersen Health Wellness, LLC	100.00%	\$ 0	\$	15	
16	V	2 Food		Petersen Health Wellness, LLC	100.00%	0		16	
17	V	3 Housekeeping		Petersen Health Wellness, LLC	100.00%	0		17	
18	V	4 Laundry		Petersen Health Wellness, LLC	100.00%	0		18	
19	V	5 Utilities		Petersen Health Wellness, LLC	100.00%	0		19	
20	V	6 Maintenance		Petersen Health Wellness, LLC	100.00%	0		20	
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Wellness, LLC	100.00%	0		21	
22	V	10 Nursing and Medical Records		Petersen Health Wellness, LLC	100.00%	0		22	
23	V	15 Mgmt. Allocation of Benefits		Petersen Health Wellness, LLC	100.00%	0		23	
24	V	17 Administrative		Petersen Health Wellness, LLC	100.00%	0		24	
25	V	19 Professional Services		Petersen Health Wellness, LLC	100.00%	27,738	27,738	25	
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Wellness, LLC	100.00%	0		26	
27	V	21 Clerical and General Office		Petersen Health Wellness, LLC	100.00%	0		27	
28	V	22 Employee Benefits & Payroll		Petersen Health Wellness, LLC	100.00%	0		28	
29	V	23 Inservice Training & Education		Petersen Health Wellness, LLC	100.00%	0		29	
30	V	24 Travel and Seminar		Petersen Health Wellness, LLC	100.00%	0		30	
31	V	25 Other Admin. Staff Transport.		Petersen Health Wellness, LLC	100.00%	0		31	
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Wellness, LLC	100.00%	0		32	
33	V	30 Depreciation		Petersen Health Wellness, LLC	100.00%	0		33	
34	V	31 Amortization		Petersen Health Wellness, LLC	100.00%	3,229	3,229	34	
35	V	32 Interest		Petersen Health Wellness, LLC	100.00%	21,705	21,705	35	
36	V	33 Real Estate Taxes		Petersen Health Wellness, LLC	100.00%	0		36	
37	V	34 Rent-Facility and Grounds		Petersen Health Wellness, LLC	100.00%	0		37	
38	V	35 Rent-Equipment & Vehicles		Petersen Health Wellness, LLC	100.00%	0		38	
39	Total		\$			\$ 52,672	\$ *	52,672	39

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

Facility Name & ID Number

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0053157

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

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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			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

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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			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 Enfield Rehabilitation & Health Care Center # 0053157 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 Enfield Rehabilitation & Health Care Center

0053157

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

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	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	9,591	\$ 2,153	1
2	2	Food	Resident Days	1,451,714	75	1,404	0	9,591	9	2
3	3	Housekeeping	Resident Days	1,451,714	75	4,904	2,743	9,591	32	3
4	5	Utilities	Resident Days	1,451,714	75	17,131	0	9,591	113	4
5	6	Maintenance	Resident Days	1,451,714	75	153,997	146,594	9,591	1,017	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,451,714	75	0	0	9,591	0	6
7	9	Medical Director	Resident Days	1,451,714	75	0	0	9,591	0	7
8	10	Nursing and Medical Records	Resident Days	1,451,714	75	4,528	1,833,909	9,591	30	8
9	10A	Therapy	Resident Days	1,451,714	75	0	0	9,591	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,451,714	75	0	0	9,591	0	10
11	17	Administrative	Resident Days	1,451,714	75	4,871,788	5,558,349	9,591	66,750	11
12	19	Professional Services	Resident Days	1,451,714	75	1,020,623	0	9,591	6,743	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,451,714	75	7,613	0	9,591	50	13
14	21	Clerical and General Office	Resident Days	1,451,714	75	3,507,569	3,782,761	9,591	23,173	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,451,714	75	1,577,706	0	9,591	10,423	15
16	23	Inservice Training & Education	Resident Days	1,451,714	75	9,731	0	9,591	64	16
17	24	Travel and Seminar	Resident Days	1,451,714	75	4,833	0	9,591	32	17
18	25	Other Admin. Staff Transport.	Resident Days	1,451,714	75	233,560	0	9,591	1,543	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,451,714	75	61,886	0	9,591	409	19
20	30	Depreciation	Resident Days	1,451,714	75	835,302	0	9,591	5,519	20
21	30	Depreciation	Resident Days	1,451,714	75	7,526	0	9,591	50	21
22	32	Interest	Resident Days	1,451,714	75	27,155	0	9,591	179	22
23	33	Real Estate Taxes	Resident Days	1,451,714	75	18,716	0	9,591	124	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,451,714	75	99,030	0	9,591	654	24
25	TOTALS					\$ 12,790,903	\$ 11,700,485		\$ 119,067	25

Facility Name & ID Number Enfield Rehabilitation & Health Care Center

0053157

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

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

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

1	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	94,618	7	\$	\$	9,591	\$	1
2	2	Food	Resident Days	94,618	7			9,591		2
3	3	Housekeeping	Resident Days	94,618	7			9,591		3
4	4	Laundry	Resident Days	94,618	7			9,591		4
5	5	Utilities	Resident Days	94,618	7			9,591		5
6	6	Maintenance	Resident Days	94,618	7			9,591		6
7	7	Mgmt. Allocation of Benefits	Resident Days	94,618	7			9,591		7
8	10	Nursing and Medical Records	Resident Days	94,618	7			9,591		8
9	15	Mgmt. Allocation of Benefits	Resident Days	94,618	7			9,591		9
10	17	Administrative	Resident Days	94,618	7			9,591		10
11	19	Professional Services	Resident Days	94,618	7	273,643		9,591	27,738	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	94,618	7			9,591		12
13	21	Clerical and General Office	Resident Days	94,618	7			9,591		13
14	22	Employee Benefits & Payroll	Resident Days	94,618	7			9,591		14
15	23	Inservice Training & Education	Resident Days	94,618	7			9,591		15
16	24	Travel and Seminar	Resident Days	94,618	7			9,591		16
17	25	Other Admin. Staff Transport.	Resident Days	94,618	7			9,591		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	94,618	7			9,591		18
19	30	Depreciation	Resident Days	94,618	7			9,591		19
20	31	Amortization	Resident Days	94,618	7	31,854		9,591	3,229	20
21	32	Interest	Resident Days	94,618	7	214,122		9,591	21,705	21
22	33	Real Estate Taxes	Resident Days	94,618	7			9,591		22
23	34	Rent-Facility and Grounds	Resident Days	94,618	7			9,591		23
24	35	Rent-Equipment & Vehicles	Resident Days	94,618	7			9,591		24
25	TOTALS					\$ 519,619	\$		\$ 52,672	25

Facility Name & ID Number Enfield Rehabilitation & Health Care Center

0053157

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

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		8	9	10									
					Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
						YES							NO	Original				Balance
A. Directly Facility Related																		
Long-Term																		
1										\$	1							
2											2							
3											3							
4											4							
5											5							
Working Capital																		
6											6							
7											7							
8											8							
9	TOTAL Facility Related					\$	\$			\$	9							
B. Non-Facility Related*																		
10											10							
11											11							
12											12							
13											13							
14	TOTAL Non-Facility Related					\$	\$			\$	21,884	14						
15	TOTALS (line 9+line14)					\$	\$			\$	21,884	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.		\$	7,584	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.)		\$	7,436	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(148)	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	7,656	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	\$	124	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7,632	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2012	6,802	8
	2013	6,701	9
	2014	6,960	10
	2015	7,363	11
	2016	7,436	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:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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: 10,476 B. General Construction Type: Exterior Brick & Concrete Frame Wood 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).

Table with 1 row containing 'N/A' and 5 empty columns.

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: 99,556 2. Number of Years Over Which it is Being Amortized: 20
3. Current Period Amortization: 3,279 4. Dates Incurred: 2013-2014

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

XI. OWNERSHIP COSTS:

Table with 6 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, 5, 6. Row 1: Facility, 75,359, 2005, \$ 15,750, 1. Row 2: 2, 2. Row 3: TOTALS, 75,359, \$ 15,750, 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	49	2005	1972	\$ 290,250	\$	25	\$ 11,610	\$ 34,053	\$ 147,387	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Door Alarm		2007	1,636		15	109	109	1,145	9
10	Air Compressor		2007	1,302		15	87	87	913	10
11	New Roof		2007	29,725		20	1,486	1,486	15,603	11
12	Awning		2008	2,569		20	128	128	1,216	12
13	Sprinkler System		2011	2,990		7	428	428	2,782	13
14	Sidewalk and Pavement Replacement		2013	35,360		25	1,414	1,414	6,363	14
15	Ceramic and vinyl tile installment-Main Hallways		2014	20,489		15	1,366	1,366	4,781	15
16	Water Heater		2014	14,671		7	2,096	2,096	7,336	16
17	Door Replacement		2016	32,581		15	2,172	2,172	3,258	17
18	Dry Valve Replacement		2016	9,790		7	1,398	1,398	2,097	18
19	Sprinkler Repair		2017	7,113		7	508	508	508	19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30	Land Improvements Booked				667			(667)		30
31	Building Booked				11,253			(11,253)		31
32	Building Improvement Booked				11,867			(11,867)		32
33										33
34	2017-Home Office Allocation-Building Improvements			4,387			105	105		34
35	2017-Home Office Allocation-Land Improvements			404			26	26		35
36										36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

	1	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)		\$ 453,267	\$ 23,787		\$ 22,933	\$ 21,589	\$ 193,389	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	\$ 27,069	\$ 2,003	\$ 2,324	\$ 321	5-10 yrs.	\$ 19,222	71
72	Current Year Purchases	2,306	247	165	(82)	7 yrs.	165	72
73	Fully Depreciated Assets	63,633					63,633	73
74	Home Office Allocation							74
75	TOTALS	\$ 93,008	\$ 2,250	\$ 2,489	\$ 239		\$ 83,020	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)	\$ 562,025	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 26,037	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 25,422	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (615)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 276,409	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.

Facility Name & ID Number Enfield Rehabilitation & Health Care Center

0053157

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

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: \$ 10,019 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>Ford E150 Van</u>	\$ <u>571.00</u>	\$ <u>4,625</u>	17
18					18
19					19
20					20
21	TOTAL		\$ 571.00	\$ 4,625	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.

**Enfield Rehabilitation & Health Care Center
0053157**

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	\$	4,714
Dishwasher		701
Copier		3,950
Home Office Allocation		654
		<u>10,019</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	\$	2,320	\$ 34,807	\$	2,320	\$ 34,807	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		369	5,531		369	5,531	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		1,777	26,662		1,777	26,662	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				10,320		10,320	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			\$	4,466	\$ 67,000	\$ 10,320	4,466	\$ 77,320	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 **Enfield Rehabilitation & Health Care Center**# **0053157**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	\$ (334,594)	\$ (334,594)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>21,183</u>)	382,920	382,920	3
4	Supply Inventory (priced at <u>Cost</u>)	5,203	5,203	4
5	Short-Term Investments			5
6	Prepaid Insurance	10,916	10,916	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	33,914	33,914	8
9	Other(specify): <u>Employee Education Loans</u>	250	250	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 98,609	\$ 98,609	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	25,750	15,750	13
14	Buildings, at Historical Cost	280,250	294,637	14
15	Leasehold Improvements, at Historical Cost	158,226	158,630	15
16	Equipment, at Historical Cost	93,008	93,008	16
17	Accumulated Depreciation (book methods)	(273,054)	(276,409)	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)	\$ 284,180	\$ 285,616	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 382,789	\$ 384,225	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 221,318	\$ 221,318	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	34,405	34,405	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,366	1,366	31
32	Accrued Real Estate Taxes(Sch.IX-B)	7,656	7,656	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	16,606	16,606	36
37	<u>Accrued Management Fees</u>	473,981	473,981	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 755,332	\$ 755,332	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Intercompany Loans</u>	17	17	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 17	\$ 17	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 755,349	\$ 755,349	46
47	TOTAL EQUITY(page 18, line 24)	\$ (372,560)	\$ (371,124)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 382,789	\$ 384,225	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (292,944)	1
2	Restatements (describe):		2
3	Adjustments Made After Cost Report Was Filed	1,122	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (291,822)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(80,738)	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)	\$ (80,738)	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)	\$ (372,560)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Enfield Rehabilitation & Health Care Center

0053157

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	\$ 1,299,249	1
2	Discounts and Allowances for all Levels	(55,720)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,243,529	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	110,304	6
7	Oxygen	643	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 110,947	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	1,197	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	31,769	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	2,621	20
21	Other Medical Services	1,977	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 37,564	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Transportation Revenue</u>	10,806	28
28a	<u>Miscellaneous Revenue</u>	2,607	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 13,413	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,405,453	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	293,549	31
32	Health Care	652,230	32
33	General Administration	373,796	33
B. Capital Expense			
34	Ownership	47,535	34
C. Ancillary Expense			
35	Special Cost Centers	37,605	35
36	Provider Participation Fee	81,476	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,486,191	40
41	Income before Income Taxes (line 30 minus line 40)**	(80,738)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (80,738)	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 934,169	44
45	Private Pay - Net Inpatient Revenue	225,880	45
46	Medicare - Net Inpatient Revenue	79,040	46
47	Other-(specify) <u>Insurance Net Inpatient Revenue</u>	4,440	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 1,243,529	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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 Enfield Rehabilitation & Health Care Center

0053157

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	1,837	1,837	\$ 54,987	\$ 29.93	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,595	3,595	73,994	20.58	3
4	Licensed Practical Nurses	6,841	7,207	129,717	18.00	4
5	CNAs & Orderlies	19,394	19,742	199,027	10.08	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,758	1,766	21,336	12.08	9
10	Activity Assistants	20	20	205	10.25	10
11	Social Service Workers	1,934	2,049	28,222	13.77	11
12	Dietician					12
13	Food Service Supervisor	1,605	1,621	23,933	14.76	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,584	5,974	62,558	10.47	15
16	Dishwashers					16
17	Maintenance Workers	1,965	1,965	29,543	15.03	17
18	Housekeepers	5,672	5,904	50,224	8.51	18
19	Laundry					19
20	Administrator	2,080	2,080	66,750	32.09	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	399	399	7,297	18.29	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	7	7	217	31.00	32
33	Other(specify) <u>Transportation</u>	1,040	1,110	10,706	9.65	33
34	TOTAL (lines 1 - 33)	53,731	55,276	\$ 758,716 *	\$ 13.73	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 2,471	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)	\$ 8,471		49

C. CONTRACT NURSES

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

Enfield Rehabilitation & Health Care Center**0053157****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)		106,040

Home Office Allocation

MusilloUnkenholt, LLC	Legal	77
Arnstein & Lehr	Legal	518
SB2	Legal	326
Miscellaneous	Legal	6
Miller Hall and Triggs	Legal	82
Smith Amundsen	Legal	32
Healthcare Resources International	Legal	57
Hunziker Law	Legal	0
Lexis Nexis	Legal	3
Baker Tilly Virchow Krause	Legal	289
Gemino	Legal	827
CliftonLarsonAllen	Accounting	925
Ginoli & Co.	Accounting	1884
Baker Tilly Virchow Krause	Accounting	58
Gemino	Accounting	6185
Miscellaneous	Computer Services	43
Change Healthcare	Computer Services	4
360 Networks	Computer Services	18
Matrix Care	Computer Services	1614
Stratus Networks	Computer Services	193
Kemper Technology	Computer Services	109
AT&T	Computer Services	3
Ability Network	Computer Services	119
CIAN	Computer Services	134
Comcast	Computer Services	7
CCH	Computer Services	7
Charter Communications	Computer Services	13
Allscripts	Computer Services	119
ATS	Computer Services	123
Citrix Systems	Computer Services	11
Optimizer	Other Prof Fees	22
Ankura	Other Prof Fees	347
David Budde	Other Prof Fees	16
Sargent Consulting	Other Prof Fees	6034
Alix Partners	Other Prof Fees	13633
Demonica Kemper	Other Prof Fees	14
Brad Barkley	Other Prof Fees	57
MPAC Healthcare	Other Prof Fees	9
Higgs Appraisal	Other Prof Fees	4
Alan Litwiller	Other Prof Fees	1
Gemino	Other Prof Fees	558

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

140,521

Facility Name & ID Number Enfield Rehabilitation & Health Care Center# 0053157

Report Period Beginning:

1/1/2017

Ending:

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. \$ 5,909 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. \$ 81,476
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. \$ 1,197
- (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. \$ 10,270
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. \$ 536
- (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