



Facility Name & ID Number Farmer City Rehab & Health Care Center

# 0050922 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	56	Skilled (SNF)	56	20,440	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	56	TOTALS	56	20,440	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	10,277	7,461	823	18,561	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,277	7,461	823	18,561	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.81%

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 9/20/2011

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 9/20/2011 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 56 and days of care provided 582

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 Farmer City Rehab & Health Care Center # 0050922 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
	<b>A. General Services</b>										
1	Dietary	143,749	11,085	662	155,496		155,496	4,167	159,663		1
2	Food Purchase		117,748		117,748		117,748	(3,522)	114,226		2
3	Housekeeping	42,302	13,954		56,256		56,256	63	56,319		3
4	Laundry	26,747	4,915		31,662		31,662		31,662		4
5	Heat and Other Utilities			53,683	53,683		53,683	219	53,902		5
6	Maintenance	31,929	5,183	12,755	49,867		49,867	6,334	56,201		6
7	Other (specify):* <u>Home Office Ben. Allocation</u>										7
8	<b>TOTAL General Services</b>	244,727	152,885	67,100	464,712		464,712	7,261	471,973		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	840,196	60,636	4,937	905,769		905,769	58	905,827		10
10a	Therapy	47,136		181,430	228,566		228,566		228,566		10a
11	Activities	65,842	763	117	66,722		66,722	(3,867)	62,855		11
12	Social Services	28,045			28,045		28,045		28,045		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Office Ben. Allocation</u>										15
16	<b>TOTAL Health Care and Programs</b>	981,219	61,399	192,484	1,235,102		1,235,102	(3,809)	1,231,293		16
	<b>C. General Administration</b>										
17	Administrative			237,300	237,300		237,300	(169,415)	67,885		17
18	Directors Fees										18
19	Professional Services			12,179	12,179		12,179	13,049	25,228		19
20	Dues, Fees, Subscriptions & Promotions			7,425	7,425		7,425	(3)	7,422		20
21	Clerical & General Office Expenses	33,015	4,428	6,027	43,470		43,470	48,509	91,979		21
22	Employee Benefits & Payroll Taxes			121,149	121,149		121,149	20,172	141,321		22
23	Inservice Training & Education			35	35		35	124	159		23
24	Travel and Seminar							62	62		24
25	Other Admin. Staff Transportation			2,719	2,719		2,719	2,986	5,705		25
26	Insurance-Prop.Liab.Malpractice			1,372	1,372		1,372	22,881	24,253		26
27	Other (specify):* <u>Home Office Ben. Allocation</u>										27
28	<b>TOTAL General Administration</b>	33,015	4,428	388,206	425,649		425,649	(61,635)	364,014		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,258,961	218,712	647,790	2,125,463		2,125,463	(58,183)	2,067,280		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 Farmer City Rehab & Health Care Center

#0050922

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	
	<b>D. Ownership</b>											
30	Depreciation			11,419	11,419		11,419	51,843	63,262			30
31	Amortization of Pre-Op. & Org.							1,206	1,206			31
32	Interest							12,515	12,515			32
33	Real Estate Taxes			1,769	1,769		1,769	26,314	28,083			33
34	Rent-Facility & Grounds			179,857	179,857		179,857	(179,857)				34
35	Rent-Equipment & Vehicles			9,204	9,204		9,204	1,266	10,470			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			202,249	202,249		202,249	(86,713)	115,536			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		18,805		18,805		18,805		18,805			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			137,942	137,942		137,942		137,942			42
43	Other (specify):*		850	41,355	42,205		42,205	(42,205)				43
44	<b>TOTAL Special Cost Centers</b>		19,655	179,297	198,952		198,952	(42,205)	156,747			44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	1,258,961	238,367	1,029,336	2,526,664		2,526,664	(187,101)	2,339,563			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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,540)	2		4
5	Telephone, TV & Radio in Resident Rooms	(7,374)	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	(19,736)	30		9
10	Interest and Other Investment Income	(276)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(154)	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	(24,177)	43		18
19	Entertainment				19
20	Contributions	(5,000)	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				24
25	Fund Raising, Advertising and Promotional	(1,684)	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	(7,791)	Various		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (69,732)		\$	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	
		<b>Amount</b>	<b>Reference</b>	
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)	(117,369)	Various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (117,369)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (187,101)		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
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
38	Medically Necessary Transport.			\$	38
39					39
40	Gift and Coffee Shops				40
41	Barber and Beauty Shops				41
42	Laboratory and Radiology				42
43	Prescription Drugs				43
44					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

<b>BHF USE ONLY</b>							
48		49		50		51	52

Farmer City Rehab & Health Care Center

ID# 0050922

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Pet Expense	\$ (1,417)	43	1
2	Labs-Part A	(858)	43	2
3	X-Rays-Part A	(545)	43	3
4	Offset Transportation Revenue	(3,867)	11	4
5	Offset Miscellaneous Nursing Supplies Income	(8)	21	5
6	Resident Flowers	(545)	43	6
7	Disallowed Special Events	(451)	43	7
8	Disallowed Chamber of Commerce Dues	(100)	20	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
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40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(7,791)		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%	\$ 4,167	\$ 4,167	1
2	V	2 Food		Petersen Health Care Management, Inc.	100.00%	18	18	2
3	V	3 Housekeeping		Petersen Health Care Management, Inc.	100.00%	63	63	3
4	V	5 Utilities		Petersen Health Care Management, Inc.	100.00%	219	219	4
5	V	6 Maintenance		Petersen Health Care Management, Inc.	100.00%	1,969	1,969	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%	58	58	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	237,300	Petersen Health Care Management, Inc.	100.00%	67,885	(169,415)	11
12	V	19 Professional Services		Petersen Health Care Management, Inc.	100.00%	13,049	13,049	12
13	V							13
14	Total		\$ 237,300			\$ 87,428	\$ * (149,872)	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%	\$ 97	\$	97	15
16	V	21 Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	44,846		44,846	16
17	V	22 Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	20,172		20,172	17
18	V	23 Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	124		124	18
19	V	24 Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	62		62	19
20	V	25 Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	2,986		2,986	20
21	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	791		791	21
22	V	27 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	10,680		10,680	22
23	V	30 Depreciation		Petersen Health Care Management, Inc.	100.00%	96		96	23
24	V	32 Interest		Petersen Health Care Management, Inc.	100.00%	347		347	24
25	V	33 Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	239		239	25
26	V	35 Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	1,266		1,266	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		\$			\$ 81,706	\$ *	81,706	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	6 Maintenance	\$	Illini Land LLC	100.00%	\$ 4,365	\$ 4,365
16	V	19 Professional Fees		Illini Land LLC	100.00%		
17	V	21 Equipment	\$	Illini Land LLC	100.00%	3,671	3,671
18	V	26 Property Insurance		Illini Land LLC	100.00%	17,946	17,946
19	V	26 Mortgage Insurance		Illini Land LLC	100.00%	4,144	4,144
20	V	30 Depreciation		Illini Land LLC	100.00%	60,899	60,899
21	V	31 Amortization		Illini Land LLC	100.00%	1,110	1,110
22	V	32 Interest	52	Illini Land LLC	100.00%	11,255	11,203
23	V	33 Real Estate Taxes		Illini Land LLC	100.00%	27,316	27,316
24	V	34 Rent-Facility & Grounds	179,857	Illini Land LLC	100.00%		(179,857)
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		\$ 179,909			\$ 130,706	\$ * (49,203)

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

Facility Name &amp; ID Number

Farmer City Rehab &amp; Health Care Center

# 0050922

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 &amp; ID Number

Farmer City Rehab &amp; Health Care Center

# 0050922

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

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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 Farmer City Rehab & Health Care Center # 0050922 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 Farmer City Rehab & Health Care Center # 0050922 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	18,561	\$ 4,167	1
2	2	Food	Resident Days	1,451,714	75	1,404	0	18,561	18	2
3	3	Housekeeping	Resident Days	1,451,714	75	4,904	2,743	18,561	63	3
4	5	Utilities	Resident Days	1,451,714	75	17,131	0	18,561	219	4
5	6	Maintenance	Resident Days	1,451,714	75	153,997	146,594	18,561	1,969	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,451,714	75	0	0	18,561	0	6
7	9	Medical Director	Resident Days	1,451,714	75	0	0	18,561	0	7
8	10	Nursing and Medical Records	Resident Days	1,451,714	75	4,528	1,833,909	18,561	58	8
9	10A	Therapy	Resident Days	1,451,714	75	0	0	18,561	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,451,714	75	0	0	18,561	0	10
11	17	Administrative	Resident Days	1,451,714	75	4,871,788	5,558,349	18,561	67,885	11
12	19	Professional Services	Resident Days	1,451,714	75	1,020,623	0	18,561	13,049	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,451,714	75	7,613	0	18,561	97	13
14	21	Clerical and General Office	Resident Days	1,451,714	75	3,507,569	3,782,761	18,561	44,846	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,451,714	75	1,577,706	0	18,561	20,172	15
16	23	Inservice Training & Education	Resident Days	1,451,714	75	9,731	0	18,561	124	16
17	24	Travel and Seminar	Resident Days	1,451,714	75	4,833	0	18,561	62	17
18	25	Other Admin. Staff Transport.	Resident Days	1,451,714	75	233,560	0	18,561	2,986	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,451,714	75	61,886	0	18,561	791	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,451,714	75	835,302	0	18,561	10,680	20
21	30	Depreciation	Resident Days	1,451,714	75	7,526	0	18,561	96	21
22	32	Interest	Resident Days	1,451,714	75	27,155	0	18,561	347	22
23	33	Real Estate Taxes	Resident Days	1,451,714	75	18,716	0	18,561	239	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,451,714	75	99,030	0	18,561	1,266	24
25	TOTALS					\$ 12,790,903	\$ 11,700,485		\$ 169,134	25

Facility Name & ID Number Farmer City Rehab & Health Care Center

# 0050922

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	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	Capmark		X	Mortgage	\$9,733.93	11/26/02	\$ 1,395,000	\$ 791,884	11/26/32	0.0570	\$ 12,496	1						
2												2						
3												3						
4												4						
5												5						
<b>Working Capital</b>																		
6												6						
7												7						
8												8						
9	<b>TOTAL Facility Related</b>				\$9,733.93		\$ 1,395,000	\$ 791,884			\$ 12,496	9						
<b>B. Non-Facility Related*</b>																		
10										Interest Income Offset		(328)	10					
11										Home Office Allocation-PHCM		347	11					
12												12						
13												13						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ 19	14						
15	<b>TOTALS (line 9+line14)</b>						\$ 1,395,000	\$ 791,884			\$ 12,515	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 4,144 Line # 26

\* 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.		\$	<b>27,679</b>	<b>1</b>
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	<b>27,359</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(320)</b>	<b>3</b>
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>28,164</b>	<b>4</b>
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		<b>5</b>
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	<b>Home Office Allocation</b>	\$	<b>239</b>	<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>28,083</b>	<b>7</b>

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	<b>2012</b>	<b>26,286</b>	<b>8</b>
	<b>2013</b>	<b>26,743</b>	<b>9</b>
	<b>2014</b>	<b>26,365</b>	<b>10</b>
	<b>2015</b>	<b>26,066</b>	<b>11</b>
	<b>2016</b>	<b>27,359</b>	<b>12</b>

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

<b>FOR BHF USE ONLY</b>			
<b>13</b>	FROM R. E. TAX STATEMENT FOR 2016	\$	<b>13</b>
<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>
<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>

**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: 28,024 B. General Construction Type: Exterior Frame Block 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: 18,042 2. Number of Years Over Which it is Being Amortized: 16  
3. Current Period Amortization: 1,206 4. Dates Incurred: 2013

Nature of Costs:

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>130,168</u>	<u>2011</u>	<u>\$ 101,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>130,168</b>		<b>\$ 101,000</b>	<b>3</b>

**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	56	2011	1964	\$ 757,118		25	30,285	\$ 34,053	\$ 196,852	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Sprinkler Repair		2009	3,584		7			3,584	9
10	Roof		2009	12,849		25	514	514	4,369	10
11	Door-Main Entrance		2009	3,698		10	370	370	3,145	11
12	Fire Alarm Panel		2010	4,728		7			4,725	12
13	A/C Unit		2010	6,850		15	456	456	3,420	13
14	Water Heater		2011	7,523		7	1,075	1,075	6,987	14
15	Grain Softeners		2011	11,950		7	1,707	1,707	11,096	15
16	Windows		2013	37,540		25	1,502	1,502	6,759	16
17	Roof Replacement		2015	149,875		25	5,996	5,996	14,990	17
18	Water Pipe Repair		2016	3,018		7	432	432	648	18
19	Garage Roof Replacement		2016	4,543		7	650	650	975	19
20	A/C Unit		2016	3,750		15	250	250	375	20
21	Rocks for Parking Lot		2017	1,600		15	53	53	53	21
22	Tree Trimming		2017	3,095		7	221	221	221	22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30	Land Improvements Booked				741			(741)		30
31	Building Booked				30,285			(30,285)		31
32	Building Improvement Booked				14,409			(14,409)		32
33										33
34	2017-Home Office Allocation-Building Improvements			8,490			204	204		34
35	2017-Home Office Allocation-Land Improvements			781			51	51		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)	\$ 1,020,992	\$ 45,435		\$ 43,766	\$ 2,099	\$ 258,199	70

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

Facility Name & ID Number Farmer City Rehab & Health Care Center

# 0050922

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

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	\$ 69,594	\$ 25,787	\$ 6,959	\$ (18,828)	5-10 yrs.	\$ 48,053	71
72	Current Year Purchases	3,298	471	236	(235)	7 yrs.		72
73	Fully Depreciated Assets	151,000					151,000	73
74	Home Office Allocation			10,425	10,425			74
75	TOTALS	\$ 223,892	\$ 26,258	\$ 17,620	\$ (8,638)		\$ 199,053	75

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

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	2012 Van	2012	\$ 18,742	\$ 625	\$ 1,876	\$ 1,251	5 yrs.	\$ 18,742	76
77										77
78										78
79										79
80	TOTALS			\$ 18,742	\$ 625	\$ 1,876	\$ 1,251		\$ 18,742	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)	\$ 1,364,626	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 72,318	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 63,262	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (9,056)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 475,994	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 Farmer City Rehab & Health Care Center

# 0050922

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	<b>TOTAL</b>				\$			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending                      Annual Rent

12.	_____ /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: \$ 4,990 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>Van</u>	<u>2016 Ford E150 Van</u>	\$ <u>685.00</u>	\$ <u>5,480</u>	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$ <b>685.00</b>	\$ <b>5,480</b>	21

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

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

**Farmer City Rehab & Health Care Center**

**0050922**

**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	\$	1,078
Dishwasher		701
Copier		1,945
Home Office Allocation		1,266
		<u>4,990</u>

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

**D. NUMBER OF CNAs TRAINED**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	5,331	\$ 79,965	\$	5,331	\$ 79,965	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		186	2,792		186	2,792	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(1), 10A(3)	2417 hrs	47,136	6,570	98,557		8,987	145,693	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				18,805		18,805	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): <u>Respiratory Therapy</u>	10A(3)			8	116		8	116	13
14	<b>TOTAL</b>			\$ 47,136	12,095	\$ 181,430	\$ 18,805	14,512	\$ 247,371	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.

**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*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 50,619	\$ 50,819	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>98,663</u> )	517,237	517,237	3
4	Supply Inventory (priced at <u>Cost</u> )	7,857	7,857	4
5	Short-Term Investments			5
6	Prepaid Insurance	11,028	12,860	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 586,741	\$ 588,773	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		101,000	13
14	Buildings, at Historical Cost		765,608	14
15	Leasehold Improvements, at Historical Cost	93,418	255,384	15
16	Equipment, at Historical Cost	87,495	242,634	16
17	Accumulated Depreciation (book methods)	(129,309)	(475,994)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		18,042	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(6,938)	20
21	Restricted Funds		219,295	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Intercompany Loans</u>	2,378,895	2,378,895	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 2,430,499	\$ 3,497,926	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,017,240	\$ 4,086,699	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 545,475	\$ 551,013	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	68,680	68,680	30
31	Accrued Taxes Payable (excluding real estate taxes)	30,162	30,162	31
32	Accrued Real Estate Taxes(Sch.IX-B)	900	28,164	32
33	Accrued Interest Payable		2,310	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Payroll Withholdings</u>	181	181	36
37	<u>Accrued Management Fees</u>	780,691	780,691	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,426,089	\$ 1,461,201	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		791,884	40
41	Bonds Payable			41
42	Deferred Compensation	1,293	1,293	42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>Intercompany Loans</u>	795	795	43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 2,088	\$ 793,972	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,428,177	\$ 2,255,173	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,589,063	\$ 1,831,526	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,017,240	\$ 4,086,699	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>1,275,079</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Adjustments Made After Cost Reports Were Filed</b>	<b>126</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>1,275,205</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>612,558</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>(286,700)</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe) <b>Capital Stock</b>	<b>(12,000)</b>	<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>313,858</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>1,589,063</b>	<b>24</b> *

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

Facility Name &amp; ID Number Farmer City Rehab &amp; Health Care Center

# 0050922

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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,920,371	1
2	Discounts and Allowances for all Levels	(144,024)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,776,347	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	315,960	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 315,960	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	3,540	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	35,730	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	1,928	20
21	Other Medical Services	1,566	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 42,764	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	276	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 276	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Transportation Revenue</u>	3,867	28
28a	<u>Miscellaneous Revenue</u>	8	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 3,875	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,139,222	30

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	464,712	31
32	Health Care	1,235,102	32
33	General Administration	425,649	33
<b>B. Capital Expense</b>			
34	Ownership	202,249	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	61,010	35
36	Provider Participation Fee	137,942	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,526,664	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	612,558	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 612,558	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 1,501,356	44
45	Private Pay - Net Inpatient Revenue	1,135,047	45
46	Medicare - Net Inpatient Revenue	125,039	46
47	Other-(specify) <u>Insurance Net Inpatient Revenue</u>	14,905	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 2,776,347	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 Farmer City Rehab & Health Care Center

# 0050922

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	2,948	2,988	\$ 76,970	\$ 25.76	1
2	Assistant Director of Nursing	2,080	2,080	39,572	19.03	2
3	Registered Nurses	3,952	4,142	100,497	24.26	3
4	Licensed Practical Nurses	10,538	10,994	201,611	18.34	4
5	CNAs & Orderlies	27,557	27,999	373,474	13.34	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,417	2,608	47,136	18.07	8
9	Activity Director	2,080	2,080	27,337	13.14	9
10	Activity Assistants	1,835	1,909	20,004	10.48	10
11	Social Service Workers	2,080	2,080	28,045	13.48	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	43,323	20.83	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,517	10,883	100,426	9.23	15
16	Dishwashers					16
17	Maintenance Workers	2,000	2,080	31,929	15.35	17
18	Housekeepers	3,571	3,647	42,302	11.60	18
19	Laundry	1,717	1,851	26,747	14.45	19
20	Administrator	2,080	2,080	67,885	32.64	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,009	2,143	33,015	15.41	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: CPC	2,149	2,209	48,072	21.76	32
33	Other(specify) <u>Transportation</u>	1,720	1,791	18,501	10.33	33
34	TOTAL (lines 1 - 33)	83,330	85,644	\$ 1,326,846 *	\$ 15.49	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	12	\$ 662	L1, C3	35
36	Medical Director	Monthly	6,000	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,862	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)	12	\$ 11,524		49

**C. CONTRACT NURSES**

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

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Karen Jones	Administrator	0	\$ 67,885	Workers' Compensation Insurance	\$ 19,628	IDPH License Fee	\$	
				Unemployment Compensation Insurance	10,635	Advertising: Employee Recruitment	2,483	
				FICA Taxes	87,717	Health Care Worker Background Check (Indicate # of checks performed <u>92</u> )	832	
				Employee Health Insurance	1,340	Miscellaneous Licenses & Permits	3,058	
				Employee Meals		Miscellaneous Dues & Subscriptions	1,052	
				Illinois Municipal Retirement Fund (IMRF)*		Home Office Allocation	97	
				Employee Relations	1,396			
				Employee Retirement	433			
				Home Office Allocation	20,172			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 67,885	TOTAL (agree to Schedule V, line 22, col.8)		\$ 7,422		
B. Administrative - Other							Less: Public Relations Expense	
Description			Amount				(100)	
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 237,300				Non-allowable advertising ( )	
							Yellow page advertising ( )	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 237,300				TOTAL (agree to Sch. V, line 20, col. 8)	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Mediacom	Computer Services		\$ 1,634				Out-of-State Travel	\$
Ginoli & Co.	Accounting Fees		5,380					
Honkamp Kruger & Co.	Accounting Fees		523					
ProTitle USA	Legal Fees		75	N/A			In-State Travel	
Ability Network	Computer Services		4,567					
							Seminar Expense	
							Home Office Allocation	62
							Entertainment Expense ( )	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 12,179	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	

\* Attach copy of IMRF notifications

\*\*See instructions.

**Farmer City Rehab & Health Care Center**

0050922

Period Beginning

1/1/2017

Period End

12/31/2017

**Schedule 21A****XIX. SUPPORT SCHEDULE****C. Professional Services**

<b>Vendor/Payee</b>	<b>Type</b>	<b>Amount</b>
Total (agree to Schedule V, line 19, column 3)		12,179
<b>Home Office Allocation</b>		
MusilloUnkenholt, LLC	Legal	149
Arnstein & Lehr	Legal	1002
SB2	Legal	630
Miscellaneous	Legal	12
Miller Hall and Triggs	Legal	159
Smith Amundsen	Legal	62
Healthcare Resources International	Legal	111
Hunziker Law	Legal	1
Lexis Nexis	Legal	6
Baker Tilly Virchow Krause	Legal	559
CliftonLarsonAllen	Accounting	1791
Ginoli & Co.	Accounting	352
Baker Tilly Virchow Krause	Accounting	112
Miscellaneous	Computer Services	82
Change Healthcare	Computer Services	7
360 Networks	Computer Services	34
Matrix Care	Computer Services	3123
Stratus Networks	Computer Services	373
Kemper Technology	Computer Services	212
AT&T	Computer Services	5
Ability Network	Computer Services	230
CIAN	Computer Services	260
Comcast	Computer Services	14
CCH	Computer Services	13
Charter Communications	Computer Services	26
Allscripts	Computer Services	231
ATS	Computer Services	238
Citrix Systems	Computer Services	22
Optimizer	Other Prof Fees	42
Ankura	Other Prof Fees	672
David Budde	Other Prof Fees	31
Sargent Consulting	Other Prof Fees	1869
Alix Partners	Other Prof Fees	454
Demonica Kemper	Other Prof Fees	28
Brad Barkley	Other Prof Fees	110
MPAC Healthcare	Other Prof Fees	16
Higgs Appraisal	Other Prof Fees	8
Alan Litwiller	Other Prof Fees	3
Total (agree to Schedule V, line 19, column 8)		<u>25,228</u>

Facility Name & ID Number Farmer City Rehab & Health Care Center# 0050922

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. \$ 25,036 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. \$ 137,942  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 3,540
- (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. \$ 3,867  
c. What percent of all travel expense relates to transportation of nurses and patients? 100  
d. Have vehicle usage logs been maintained? Adequate records have been maintained.  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes  
g. Does the facility transport residents to and from day training? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Ginoli and Company
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. No  
Attach invoices and a summary of services for all architect and appraisal fees