FOR BHF USE

LL1

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

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

I. IDPH License ID Number: 0053165

Facility Name: Havana Health Care Center

Address: 609 N. Harpham (Number) Havana (City) 62644 (Zip Code)

County: Mason

Telephone Number: (309) 543-6121 **Fax #** (309) 543-1233

HFS ID Number:

Date of Initial License for Current Owners: 03/01/01

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2017 to 12/31/2017 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed)
(Date)
(Type or Print Name) Mark B. Petersen
(Title) Chief Executive Officer

Paid Preparer
(Signed)
(Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF		3,618	1,377	4,995	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	15,977			15,977	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,977	3,618	1,377	20,972	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 58.63%

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)
Jail Meals

F. Does the facility maintain a daily midnight census?

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

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

I. On what date did you start providing long term care at this location?
Date started 3/1/2001

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 3/1/2001 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 20 and days of care provided 1,180

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] 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 Havana Health Care Center # 0053165 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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	167,113	25,333		192,446		192,446	4,708	197,154			1
2	Food Purchase		186,326		186,326		186,326	(198,421)	(12,095)			2
3	Housekeeping	107,076	12,562		119,638		119,638	71	119,709			3
4	Laundry	42,009	6,200		48,209		48,209		48,209			4
5	Heat and Other Utilities			64,874	64,874		64,874	(4,301)	60,573			5
6	Maintenance	28,110	8,033	35,034	71,177		71,177	2,225	73,402			6
7	Other (specify):* Home Office Ben. Allocation											7
8	TOTAL General Services	344,308	238,454	99,908	682,670		682,670	(195,718)	486,952			8
	B. Health Care and Programs											
9	Medical Director			19,200	19,200		19,200		19,200			9
10	Nursing and Medical Records	951,646	95,285	6,966	1,053,897		1,053,897	(1,490)	1,052,407			10
10a	Therapy		101	300,363	300,464		300,464		300,464			10a
11	Activities	55,279	949	284	56,512		56,512	(15,847)	40,665			11
12	Social Services	36,594			36,594		36,594		36,594			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Office Ben. Allocation											15
16	TOTAL Health Care and Programs	1,043,519	96,335	326,813	1,466,667		1,466,667	(17,337)	1,449,330			16
	C. General Administration											
17	Administrative			278,800	278,800		278,800	(202,133)	76,667			17
18	Directors Fees											18
19	Professional Services			10,956	10,956		10,956	47,280	58,236			19
20	Dues, Fees, Subscriptions & Promotions			10,504	10,504		10,504	(15)	10,489			20
21	Clerical & General Office Expenses	33,485	6,659	14,862	55,006		55,006	50,528	105,534			21
22	Employee Benefits & Payroll Taxes			170,313	170,313		170,313	22,792	193,105			22
23	Inservice Training & Education			(237)	(237)		(237)	141	(96)			23
24	Travel and Seminar							70	70			24
25	Other Admin. Staff Transportation			12,904	12,904		12,904	3,374	16,278			25
26	Insurance-Prop.Liab.Malpractice			32,357	32,357		32,357	894	33,251			26
27	Other (specify):* Home Office Ben. Allocation											27
28	TOTAL General Administration	33,485	6,659	530,459	570,603		570,603	(77,069)	493,534			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,421,312	341,448	957,180	2,719,940		2,719,940	(290,124)	2,429,816			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Havana Health Care Center #0053165 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			101,543	101,543		101,543	8,572	110,115			30
31	Amortization of Pre-Op. & Org.							109	109			31
32	Interest			83,864	83,864		83,864	8,012	91,876			32
33	Real Estate Taxes			77,343	77,343		77,343	270	77,613			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			32,884	32,884		32,884	1,431	34,315			35
36	Other (specify):*											36
37	**TOTAL Ownership**			295,634	295,634		295,634	18,394	314,028			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		31,739		31,739		31,739		31,739			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			172,925	172,925		172,925		172,925			42
43	Other (specify):*	10,556	518	140,367	151,441		151,441	(151,441)				43
44	**TOTAL Special Cost Centers**	10,556	32,257	313,292	356,105		356,105	(151,441)	204,664			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,431,868	373,705	1,566,106	3,371,679		3,371,679	(423,171)	2,948,508			45

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

Facility Name & ID Number Havana Health Care Center # 0053165 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(5,341)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,531)	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	(3,495)	30		9
10	Interest and Other Investment Income	(1,085)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(507)	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	(19,568)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(60,000)	43		24
25	Fund Raising, Advertising and Promotional	(1,206)	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	(282,948)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (376,681)		$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	6,509	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 6,509		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (370,172)		37

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

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

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

Havana Health Care Center

ID# 0053165

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs-Part A	$ (51,611)	43	1
2	X-Rays-Part A	(3,659)	43	2
3	Offset of Office Supplies Income	(144)	21	3
4	Offset of Jail Meals Revenue	(193,100)	2	4
5	Offset of Transportation Revenue	(15,847)	11	5
6	Disallowed Special Events	1,169	43	6
7	Disallowed Chamber of Commerce Dues	(125)	20	7
8	Disallowed Marketing Expenses	(11,074)	43	8
9	Offset Nursing Supply Expense	(1,555)	10	9
10	Offset Electricity Security Deposit Refund	(4,548)	5	10
11	Vending Machine Expense	(2,454)	43	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
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32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(282,948)		49

Facility Name & ID Number Havana Health Care Center # 0053165 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	$	Petersen Health Care Management, Inc.	100.00%	$ 4,708	$ 4,708	1
2	V	2	Food		Petersen Health Care Management, Inc.	100.00%	20	20	2
3	V	3	Housekeeping		Petersen Health Care Management, Inc.	100.00%	71	71	3
4	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	247	247	4
5	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	2,225	2,225	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%	65	65	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	278,800	Petersen Health Care Management, Inc.	100.00%	76,667	(202,133)	11
12	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	14,744	14,744	12
13	V								13
14	Total			$ 278,800			$ 98,747	$ * (180,053)	14

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

Facility Name & ID Number Havana Health Care Center # 0053165 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	20	Dues, Fees, Subs & Promotions	$	Petersen Health Care Management, Inc.	100.00%	$ 110	$ 110	15
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	50,672	50,672	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	22,792	22,792	17
18	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	141	141	18
19	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	70	70	19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	3,374	3,374	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	894	894	21
22	V	27	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	12,067	12,067	22
23	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	109	109	23
24	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	392	392	24
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	270	270	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	1,431	1,431	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			$			$ 92,322	$ * 92,322	39

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

Facility Name & ID Number Havana Health Care Center # 0053165 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Petersen Health Quality, LLC	100.00%	$ 0	$	15
16	V	2	Food		Petersen Health Quality, LLC	100.00%	0		16
17	V	3	Housekeeping		Petersen Health Quality, LLC	100.00%	0		17
18	V	4	Laundry		Petersen Health Quality, LLC	100.00%	0		18
19	V	5	Utilities		Petersen Health Quality, LLC	100.00%	0		19
20	V	6	Maintenance		Petersen Health Quality, LLC	100.00%	0		20
21	V	7	Mgmt. Allocation of Benefits		Petersen Health Quality, LLC	100.00%	0		21
22	V	10	Nursing and Medical Records		Petersen Health Quality, LLC	100.00%	0		22
23	V	15	Mgmt. Allocation of Benefits		Petersen Health Quality, LLC	100.00%	0		23
24	V	17	Administrative		Petersen Health Quality, LLC	100.00%	0		24
25	V	19	Professional Services		Petersen Health Quality, LLC	100.00%	35,978	35,978	25
26	V	20	Dues, Fees, Subs & Promotions		Petersen Health Quality, LLC	100.00%	0		26
27	V	21	Clerical and General Office		Petersen Health Quality, LLC	100.00%	0		27
28	V	22	Employee Benefits & Payroll		Petersen Health Quality, LLC	100.00%	0		28
29	V	23	Inservice Training & Education		Petersen Health Quality, LLC	100.00%	0		29
30	V	24	Travel and Seminar		Petersen Health Quality, LLC	100.00%	0		30
31	V	25	Other Admin. Staff Transport.		Petersen Health Quality, LLC	100.00%	0		31
32	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Quality, LLC	100.00%	0		32
33	V	30	Depreciation		Petersen Health Quality, LLC	100.00%	84	84	33
34	V	31	Amortization		Petersen Health Quality, LLC	100.00%	0		34
35	V	32	Interest		Petersen Health Quality, LLC	100.00%	58,178	58,178	35
36	V	33	Real Estate Taxes		Petersen Health Quality, LLC	100.00%	0		36
37	V	34	Rent-Facility and Grounds		Petersen Health Quality, LLC	100.00%	0		37
38	V	35	Rent-Equipment & Vehicles		Petersen Health Quality, LLC	100.00%	0		38
39	Total			$			$ 94,240	$ * 94,240	39

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

Facility Name & ID Number Havana Health Care Center # 0053165 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, L	Peoria	Mgmt/Bookkeeping	1
2			Arcola Health Care Center	Arcola	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	2
3			Aspen Rehab & Health Care	Silvis	Petersen Health Care,	Peoria	Mgmt/Bookkeeping	3
4			Batavia Rehab & Health Care Center	Batavia	Petersen Health Entert	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 Systen	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 LL	Peoria	Hospitality	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care M	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 V	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care X	Peoria	Lessor	13
14			Decatur Rehab & Health Care Center	Decatur	Midwest Health Opera	Peoria	Mgmt/Bookkeeping	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Health Prope	Peoria	Mgmt/Bookkeeping	15
16			Eastview Terrace	Sullivan	Petersen Roseville, LL	Roseville	Lessor	16
17			El Paso Health Care Center	El Paso	Petersen Health Juncti	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Petersen Health Qualit	Peoria	Mgmt/Bookkeeping	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Health and W	Peoria	Mgmt/Bookkeeping	19
20			Flanagan Rehab & Health Care Center	Flanagan	Petersen 24, LLC	Peoria	Hospitality	20
21			Flora Gardens Care Center	Flora				21
22			Flora Health Care Center	Flora				22
23			Fondulac Rehab & Health Care Center	East Peoria				23
24			Havana Health Care Center	Havana				24
25			Illini Heritage Rehab & Health Care	Champaign				25
26			Jonesboro Rehab & Health Care Center	Jonesboro				26
27			Kewanee Care Home	Kewanee				27
28			LaHarpe Davier Health Care Center	LaHarpe				28
29			Lebanon Care Center	Lebanon				29
30			Marigold Rehab & Health Care Center	Galesburg				30

Facility Name & ID Number Havana Health Care Center # 0053165 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Mason Point	Sullivan				1
2			McLeansboro Rehab & Health Care Center	McLeansboro				2
3			Mt. Vernon Health Care Center	Mt. Vernon				3
4			Newman Rehab & Health Care Center	Newman				4
5			Nokomis Rehab & Health Care Center	Nokomis				5
6			North Aurora Care Center	North Aurora				6
7			Palm Terrace of Mattoon	Mattoon				7
8			Piper City Rehab & Living Center	Piper City				8
9			Pleasant View Rehab & Health Care Center	Morrison				9
10			Polo Rehabilitation & Health Care Center	Polo				10
11			Prairie City Rehab & Health Care Center	Prairie City				11
12			Robings Manor Nursing Home	Brighton				12
13			Rochelle Gardens	Rochelle				13
14			Rochelle Rehab & Health Care Center	Rochelle				14
15			Rock Falls Rehab & Health Care Center	Rock Falls				15
16			Arrow Wood Independent Living	Rock Falls				16
17			Roseville Rehab and Health Care Center	Roseville				17
18			Rosiclare Rehab & Health Care Center	Rosiclare				18
19			Royal Oaks Care Center	Kewanee				19
20			Sandwich Rehab & Health Care Center	Sandwich				20
21			Iron Wood Independent Living	Sandwich				21
22			Shawnee Rose Care Center	Harrisburg				22
23			Shelbyville Rehab & Health Care Center	Shelbyville				23
24			South Elgin Rehab & Health Care Center	South Elgin				24
25			Sullivan Health Care Center	Sullivan				25
26			Sunset Manor Nursing Home	Canton				26
27			Swansea Rehab & Health Care	Swansea				27
28			Timbercreek Rehab & Health Center	Pekin				28
29			Toulon Health Care Center	Toulon				29
30			Tuscola Health Care Center	Tuscola				30

Facility Name & ID Number Havana Health Care Center # 0053165 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 Havana Health Care Center # 0053165 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			Cornerstone Health and Rehabilitation	Peoria				1
2			Rock River Gardens	Sterling				2
3			Sauk Valley Senior Living & Rehabilitation	Rock Falls				3
4			Courtyard Estates of Farmington	Farmington				4
5			Courtyard Estates of Knoxville	Knoxville				5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Havana Health Care Center # 0053165 Report Period Beginning: 1/1/2017 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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		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 Havana Health Care Center # 0053165 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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	1,451,714	75	$ 325,901	$ 376,129	20,972	$ 4,708	1
2	2	Food	Resident Days	1,451,714	75	1,404	0	20,972	20	2
3	3	Housekeeping	Resident Days	1,451,714	75	4,904	2,743	20,972	71	3
4	5	Utilities	Resident Days	1,451,714	75	17,131	0	20,972	247	4
5	6	Maintenance	Resident Days	1,451,714	75	153,997	146,594	20,972	2,225	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,451,714	75	0	0	20,972	0	6
7	9	Medical Director	Resident Days	1,451,714	75	0	0	20,972	0	7
8	10	Nursing and Medical Records	Resident Days	1,451,714	75	4,528	1,833,909	20,972	65	8
9	10A	Therapy	Resident Days	1,451,714	75	0	0	20,972	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,451,714	75	0	0	20,972	0	10
11	17	Administrative	Resident Days	1,451,714	75	4,871,788	5,558,349	20,972	76,667	11
12	19	Professional Services	Resident Days	1,451,714	75	1,020,623	0	20,972	14,744	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,451,714	75	7,613	0	20,972	110	13
14	21	Clerical and General Office	Resident Days	1,451,714	75	3,507,569	3,782,761	20,972	50,672	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,451,714	75	1,577,706	0	20,972	22,792	15
16	23	Inservice Training & Education	Resident Days	1,451,714	75	9,731	0	20,972	141	16
17	24	Travel and Seminar	Resident Days	1,451,714	75	4,833	0	20,972	70	17
18	25	Other Admin. Staff Transport.	Resident Days	1,451,714	75	233,560	0	20,972	3,374	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,451,714	75	61,886	0	20,972	894	19
20	30	Depreciation	Resident Days	1,451,714	75	835,302	0	20,972	12,067	20
21	31	Amortization	Resident Days	1,451,714	75	7,526	0	20,972	109	21
22	32	Interest	Resident Days	1,451,714	75	27,155	0	20,972	392	22
23	33	Real Estate Taxes	Resident Days	1,451,714	75	18,716	0	20,972	270	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,451,714	75	99,030	0	20,972	1,431	24
25	TOTALS					$ 12,790,903	$ 11,700,485		$ 191,069	25

Facility Name & ID Number Havana Health Care Center # 0053165 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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	83,607	13	$	$	20,972	$	1
2	2	Food	Resident Days	83,607	13			20,972		2
3	3	Housekeeping	Resident Days	83,607	13			20,972		3
4	4	Laundry	Resident Days	83,607	13			20,972		4
5	5	Utilities	Resident Days	83,607	13			20,972		5
6	6	Maintenance	Resident Days	83,607	13			20,972		6
7	7	Mgmt. Allocation of Benefits	Resident Days	83,607	13			20,972		7
8	10	Nursing and Medical Records	Resident Days	83,607	13			20,972		8
9	15	Mgmt. Allocation of Benefits	Resident Days	83,607	13			20,972		9
10	17	Administrative	Resident Days	83,607	13			20,972		10
11	19	Professional Services	Resident Days	83,607	13	143,430		20,972	35,978	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	83,607	13			20,972		12
13	21	Clerical and General Office	Resident Days	83,607	13			20,972		13
14	22	Employee Benefits & Payroll	Resident Days	83,607	13			20,972		14
15	23	Inservice Training & Education	Resident Days	83,607	13			20,972		15
16	24	Travel and Seminar	Resident Days	83,607	13			20,972		16
17	25	Other Admin. Staff Transport.	Resident Days	83,607	13			20,972		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	83,607	13			20,972		18
19	30	Depreciation	Resident Days	83,607	13	333		20,972	84	19
20	31	Amortization	Resident Days	83,607	13			20,972		20
21	32	Interest	Resident Days	83,607	13	231,932		20,972	58,178	21
22	33	Real Estate Taxes	Resident Days	83,607	13			20,972		22
23	34	Rent-Facility and Grounds	Resident Days	83,607	13			20,972		23
24	35	Rent-Equipment & Vehicles	Resident Days	83,607	13			20,972		24
25	TOTALS					$ 375,695	$		$ 94,240	25

Facility Name & ID Number Havana Health Care Center # 0053165 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	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Gemino		X	Mortgage	Varies	3/27/15	$ 1,677,770	$ 1,552,670	3/26/40	Varies	$ 83,864	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 1,677,770	$ 1,552,670			$ 83,864	9
	B. Non-Facility Related*											
10								Interest Income Offset			(1,085)	10
11								Home Office Allocation-PHQ			8,705	11
12								Home Office Allocation-PHCM			392	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 8,012	14
15	TOTALS (line 9+line14)						$ 1,677,770	$ 1,552,670			$ 91,876	15

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

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

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

Facility Name & ID Number Havana Health Care Center # 0053165 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	76,809	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.)	$	75,936	2
3. Under or (over) accrual (line 2 minus line 1).	$	(873)	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)	$	78,216	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **Home Office Allocation**		270	
TOTAL REFUND $ **For** **Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	77,613	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	71,692	8
	2013	72,283	9
	2014	71,908	10
	2015	74,582	11
	2016	75,936	12

Accrual based on prior year tax bill.

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

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.** This denial must be no more than four years old at the time the cost report is filed.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Havana Health Care Center COUNTY Mason

FACILITY IDPH LICENSE NUMBER 0053165

CONTACT PERSON REGARDING THIS REPORT MIKE KOCHER

TELEPHONE (309)689-5850 FAX #: (309)691-8622

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2016 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2016.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	05-31-300-006	Long-Term Care Facility	$ 75,904.52	$ 75,904.52
2.	05-31-304-013	Land	$ 31.06	$ 31.06
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 75,935.58	$ 75,935.58

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Havana Health Care Center # 0053165 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,208 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

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

1. Total Amount Incurred: 95,556 2. Number of Years Over Which it is Being Amortized: 20

3. Current Period Amortization: 109 4. Dates Incurred: 2013-2014

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	418,945	2001	$ 200,000	1
2					2
3	TOTALS	418,945		$ 200,000	3

Facility Name & ID Number Havana Health Care Center # 0053165 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	98		2001	1971	$ 1,314,000	$	35	$ 37,543	$ 34,053	$ 619,459	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Flooring			2001	5,875		20	295	295	4,867	9
10	Landscaping			2001	8,984		20	449	449	7,409	10
11	A/C Heating Unit			2001	2,046		20	102	102	1,807	11
12	Ceiling Tiles			2003	9,516		20	476	476	6,902	12
13	Doors			2004	2,305		20	115	115	1,553	13
14	Nursing Station			2004	8,100		20	405	405	5,468	14
15	Furnace			2004	3,382		20	169	169	2,282	15
16	Water Heater			2004	2,281		20	114	114	1,539	16
17	Concrete slab work			2005	3,919		20	196	196	2,450	17
18	Roofing			2006	2,991		20	150	150	1,725	18
19	Walk-In Freezer			2007	14,817		20	741	741	7,780	19
20	Roof Repairs			2008	2,890		20	144	144	1,368	20
21	A/C Unit			2010	3,091		7	218	218	3,091	21
22	Fire Alarm Panel			2010	2,648		7	191	191	2,648	22
23	Roof Repairs			2010	10,896		7	782	782	10,896	23
24	Sprinkler System Replacement			2010	96,315		15	6,422	6,422	48,165	24
25	Wastewater Pump			2011	8,141		10	814	814	5,291	25
26	Generator Installation			2011	7,000		10	700	700	4,550	26
27	Water Heater			2013	3,673		7	524	524	2,358	27
28	Water Heater			2013	3,572		7	510	510	2,295	28
29	A/C Condenser			2013	6,265		15	418	418	1,881	29
30	Roof Replacement			2013	157,330		25	6,294	6,294	28,323	30
31	Landscaping			2013	3,600		15	240	240	1,080	31
32	Water Heater			2013	9,713		7	1,388	1,388	6,246	32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Havana Health Care Center # 0053165 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Sprinkler System Repair	2014	$ 5,807	$	7	$ 830	$ 830	$ 2,905	37
38	Sprinkler Head Installations	2014	4,955		7	708	708	2,478	38
39	Parking Lot Repaving	2014	55,985		15	3,732	3,732	13,062	39
40	Landscaping	2014	6,237		7	891	891	3,119	40
41	Nursing Alarm System Replacement	2014	14,699		7	2,100	2,100	7,350	41
42	Exterior Fencing Around Facility	2014	5,150		15	343	343	1,201	42
43	Soffit Replacements	2014	11,122		15	741	741	2,594	43
44	Tile, Floor, Painting in Bedrooms, Common Areas, Hallways	2014	218,407		15	14,560	14,560	50,960	44
45	Awning	2014	3,159		7	452	226	1,017	45
46	Nurses Station	2014	11,341		15	756	756	2,646	46
47	Exterior Signage	2015	3,397		7	486	486	1,215	47
48	Sewer Drain Repair	2017	3,830		7	274	274	274	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	Building Booked			33,692			(33,692)		64
65	Building Improvement Booked			46,541			(46,541)		65
66									66
67	2017-Home Office Allocation-Building Improvements		7,329			176	176		67
68	2017-Home Office Allocation-Land Improvements		674			44	44		68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,045,442	$ 80,233		$ 85,493	$ 1,544	$ 870,254	70

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

Facility Name & ID Number Havana Health Care Center # 0053165 Report Period Beginning: 1/1/2017 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	$ 160,636	$ 21,216	$ 12,586	$ (8,630)	5-10 yrs.	$ 55,870	71
72	Current Year Purchases	2,645	94	189	95	7 yrs.	189	72
73	Fully Depreciated Assets	422,725					422,725	73
74	Home Office Allocation			11,847	11,847			74
75	TOTALS	$ 586,006	$ 21,310	$ 24,622	$ 3,312		$ 478,784	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Use	2009 Ford E250 Van	2009	34,172	$	$	$	5 yrs.	$ 34,172	76
77										77
78										78
79										79
80	TOTALS			$ 34,172	$	$	$		$ 34,172	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,865,620	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 101,543	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 110,115	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 8,572	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,383,210	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 Havana Health Care Center # 0053165 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

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: _____ *

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	$

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: $ 34,315 Description: See Attached Schedule 14A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

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

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

Havana Health Care Center
0053165
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	$	30,018
Dishwasher		701
Copier		2,165
Home Office Allocation		1,431
		34,315

Facility Name & ID Number Havana Health Care Center # 0053165 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Havana Health Care Center # 0053165 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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

	1	2		3	4		5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)			Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost					
1	Licensed Occupational Therapist	10A(3)	hrs	$	8,236	$	123,546	$	8,236	$ 123,546	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		6,570		98,556		6,570	98,556	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		5,210		78,145	101	5,210	78,246	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					31,739		31,739	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Other (specify): Respiratory Therapy	10A(3)			8		116		8	116	12
13	Other (specify):										13
14	TOTAL			$	20,024	$	300,363	$ 31,840	20,024	$ 332,203	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.

STATE OF ILLINOIS

Facility Name & ID Number Havana Health Care Center **#** 0053165 **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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 257,253	$ 257,253	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 107,348)	1,290,390	1,290,390	3
4	Supply Inventory (priced at Cost)	15,521	15,521	4
5	Short-Term Investments			5
6	Prepaid Insurance	21,920	21,920	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Employee Education Loans	400	400	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,585,484	$ 1,585,484	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	208,984	200,000	13
14	Buildings, at Historical Cost	1,314,000	1,321,329	14
15	Leasehold Improvements, at Historical Cost	723,439	724,113	15
16	Equipment, at Historical Cost	620,178	620,178	16
17	Accumulated Depreciation (book methods)	(1,363,231)	(1,383,210)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	67,321	67,321	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,570,691	$ 1,549,731	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,156,175	$ 3,135,215	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 726,358	$ 726,358	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	89,509	89,509	30
31	Accrued Taxes Payable (excluding real estate taxes)	105,849	105,849	31
32	Accrued Real Estate Taxes(Sch.IX-B)	78,216	78,216	32
33	Accrued Interest Payable	7,015	7,015	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	39,779	39,779	36
37	Accrued Management Fees	384,403	384,403	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,431,129	$ 1,431,129	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,552,670	1,552,670	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,552,670	$ 1,552,670	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,983,799	$ 2,983,799	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 172,376	$ 151,416	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,156,175	$ 3,135,215	48

***(See instructions.)**

Facility Name & ID Number Havana Health Care Center # 0053165 **Report Period Beginning:** 1/1/2017 **Ending:** 12/31/2017

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (118,473)	1
2	Restatements (describe):		2
3	**Adjustments Made After Cost Report Was Filed**	5,546	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (112,927)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	285,303	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)**	$ 285,303	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)**	$ 172,376	24 *

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

Facility Name & ID Number Havana Health Care Center # 0053165 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	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,037,235	1
2	Discounts and Allowances for all Levels	(235,317)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,801,918	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	521,707	6
7	Oxygen	1,602	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 523,309	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	5,341	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	57,985	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	43,269	20
21	Other Medical Services	8,881	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 115,476	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,085	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,085	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Transportation Revenue	15,847	28
28a	Jail Meals and Miscellaneous Revenue	199,347	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 215,194	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,656,982	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	682,670	31
32	Health Care	1,466,667	32
33	General Administration	570,603	33
	B. Capital Expense		
34	Ownership	295,634	34
	C. Ancillary Expense		
35	Special Cost Centers	183,180	35
36	Provider Participation Fee	172,925	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,371,679	40
41	**Income before Income Taxes (line 30 minus line 40)****	285,303	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 285,303	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,068,764	44
45	Private Pay - Net Inpatient Revenue	513,268	45
46	Medicare - Net Inpatient Revenue	195,783	46
47	Other-(specify) Insurance Net Inpatient Revenue	24,103	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,801,918	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Havana Health Care Center # 0053165 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,080	$ 55,551	$ 26.71	1
2	Assistant Director of Nursing	2,080	2,080	38,572	18.54	2
3	Registered Nurses	2,755	2,798	66,707	23.84	3
4	Licensed Practical Nurses	14,735	15,303	312,859	20.44	4
5	CNAs & Orderlies	34,419	35,523	421,677	11.87	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,767	1,767	23,579	13.34	9
10	Activity Assistants	787	787	9,009	11.45	10
11	Social Service Workers	2,080	2,080	36,594	17.59	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	30,612	14.72	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,426	13,843	136,501	9.86	15
16	Dishwashers					16
17	Maintenance Workers	1,778	1,826	28,110	15.39	17
18	Housekeepers	9,312	9,461	107,076	11.32	18
19	Laundry	4,038	4,157	42,009	10.11	19
20	Administrator	2,080	2,080	76,667	36.86	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,080	2,080	33,485	16.10	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	43	43	1,011	23.51	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Page 20A	5,385	5,457	88,516	16.22	33
34	TOTAL (lines 1 - 33)	100,925	103,445	$ 1,508,535 *	$ 14.58	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	19,200	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	5,284	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)		$ 24,484		49

C. CONTRACT NURSES

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

Havana Health Care Center
0053165
Period Beginning **1/1/2017**
Period End **12/31/2017**

Schedule 20A

XVIII. Staffing and Salary Costs

		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator		2,283	2,355	55,269	23.47
Transportation		2,401	2,401	22,691	9.45
Marketing		701	701	10,556	15.06
	TOTAL	5,385	5,457	88,516	

Facility Name & ID Number Havana Health Care Center # 0053165 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Margaret Ferris	Administrator	0	$ 76,667
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 76,667

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 278,800
TOTAL (agree to Schedule V, line 17, col. 3)	$ 278,800
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Honkamp Krueger & Co.	Accounting Fees	$ 738
Verla Simmons	Legal Fees	1,000
CenturyLink	Computer Services	1,031
Cass Communications	Computer Services	1,320
Ability Network	Computer Services	4,567
Sorling Northrup	Legal Fees	2,300
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 10,956

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 34,349
Unemployment Compensation Insurance	26,254
FICA Taxes	106,136
Employee Health Insurance	1,715
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	1,324
Employee Retirement	535
Home Office Allocation	22,792
TOTAL (agree to Schedule V, line 22, col.8)	$ 193,105

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

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	75
Health Care Worker Background Check	
(Indicate # of checks performed 468)	4,290
Miscellaneous Licenses & Permits	1,082
Miscellaneous Dues & Subscriptions	1,077
Home Office Allocation	110
Less: Public Relations Expense	(125)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,489

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Home Office Allocation	70
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 70

* Attach copy of IMRF notifications

**See instructions.

Havana Health Care Center
0053165
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)		10,956
Home Office Allocation		
MusilloUnkenholt, LLC	Legal	168
Arnstein & Lehr	Legal	1132
SB2	Legal	712
Miscellaneous	Legal	13
Miller Hall and Triggs	Legal	180
Smith Amundsen	Legal	70
Healthcare Resources International	Legal	125
Hunziker Law	Legal	1
Lexis Nexis	Legal	7
Baker Tilly Virchow Krause	Legal	632
Secretary of State	Legal	50
Gemino	Legal	46
CliftonLarsonAllen	Accounting	3463
Ginoli & Co.	Accounting	4371
Baker Tilly Virchow Krause	Accounting	126
Gemino	Accounting	1942
Miscellaneous	Computer Services	98
Change Healthcare	Computer Services	8
360 Networks	Computer Services	39
Matrix Care	Computer Services	3529
Stratus Networks	Computer Services	421
Kemper Technology	Computer Services	239
AT&T	Computer Services	6
Ability Network	Computer Services	260
CIAN	Computer Services	293
Comcast	Computer Services	16
CCH	Computer Services	14
Charter Communications	Computer Services	29
Allscripts	Computer Services	261
ATS	Computer Services	268
Citrix Systems	Computer Services	25
Optimizer	Other Prof Fees	47
Ankura	Other Prof Fees	760
David Budde	Other Prof Fees	35
Sargent Consulting	Other Prof Fees	14653
Alix Partners	Other Prof Fees	13055
Demonica Kemper	Other Prof Fees	31
Brad Barkley	Other Prof Fees	124
MPAC Healthcare	Other Prof Fees	19
Higgs Appraisal	Other Prof Fees	9
Alan Litwiller	Other Prof Fees	3
Total (agree to Schedule V, line 19, column 8)		58,236

Facility Name & ID Number Havana Health Care Center # 0053165 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. $ **24,470** 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. $ **172,925**
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. $ **5,341**

(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. $ **15,847**
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