

		FOR BHF USE					

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

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.

<p>I. IDPH License ID Number: <u>0053066</u></p> <p>Facility Name: <u>Shelbyville Rehabilitation & Health Care Center</u></p> <p>Address: <u>2116 South 3rd & Dacey Drive</u> <u>Shelbyville</u> <u>62565</u> <small>Number City Zip Code</small></p> <p>County: <u>Shelby</u></p> <p>Telephone Number: <u>(217) 774-2138</u> Fax # <u>(217) 774-2317</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>10/1/2005</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Mike Kocher</u> Telephone Number: <u>(309) 689-5850</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2017</u> to <u>12/31/2017</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 15%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Mark B. Petersen</u></td> <td></td> </tr> <tr> <td></td> <td>(Title) <u>Chief Executive Officer</u></td> <td></td> </tr> <tr> <td rowspan="5">Paid Preparer</td> <td>(Signed) _____</td> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> <td></td> </tr> <tr> <td>(Firm Name & Address) _____</td> <td></td> </tr> <tr> <td>(Telephone) <u>()</u> _____</td> <td>Fax # () _____</td> </tr> <tr> <td colspan="2"> MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 </td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) <u>Mark B. Petersen</u>			(Title) <u>Chief Executive Officer</u>		Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) _____		(Firm Name & Address) _____		(Telephone) <u>()</u> _____	Fax # () _____	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																										
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Facility Name & ID Number Shelbyville Rehabilitation & Health Care Center

0053066 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	12	Skilled (SNF)	12	4,380	1
2		Skilled Pediatric (SNF/PED)			2
3	68	Intermediate (ICF)	68	24,820	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	80	TOTALS	80	29,200	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		3,438	905	4,343	8
9	SNF/PED					9
10	ICF	11,063			11,063	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,063	3,438	905	15,406	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 52.76%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 10/1/2005

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 12 and days of care provided 812

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 Shelbyville Rehabilitation & Health Care Cen # 0053066 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	112,534	12,781		125,315		125,315	3,459	128,774		1
2	Food Purchase		95,626		95,626		95,626	(1,680)	93,946		2
3	Housekeeping	85,631	12,474		98,105		98,105	52	98,157		3
4	Laundry	876	7,073		7,949		7,949		7,949		4
5	Heat and Other Utilities			65,420	65,420		65,420	(1,169)	64,251		5
6	Maintenance	30,215	5,408	12,476	48,099		48,099	1,634	49,733		6
7	Other (specify):* <u>Home Office Ben. Allocation</u>										7
8	TOTAL General Services	229,256	133,362	77,896	440,514		440,514	2,296	442,810		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	778,334	88,408	6,015	872,757		872,757	(544)	872,213		10
10a	Therapy		152	94,269	94,421		94,421		94,421		10a
11	Activities	41,412	39	475	41,926		41,926	(4,596)	37,330		11
12	Social Services	21,208	117		21,325		21,325		21,325		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Office Ben. Allocation</u>										15
16	TOTAL Health Care and Programs	840,954	88,716	112,759	1,042,429		1,042,429	(5,140)	1,037,289		16
	C. General Administration										
17	Administrative			200,500	200,500		200,500	(137,700)	62,800		17
18	Directors Fees										18
19	Professional Services			7,656	7,656		7,656	55,386	63,042		19
20	Dues, Fees, Subscriptions & Promotions			4,066	4,066		4,066	81	4,147		20
21	Clerical & General Office Expenses	24,640	2,794	15,156	42,590		42,590	37,166	79,756		21
22	Employee Benefits & Payroll Taxes			124,518	124,518		124,518	16,743	141,261		22
23	Inservice Training & Education							103	103		23
24	Travel and Seminar							51	51		24
25	Other Admin. Staff Transportation			5,207	5,207		5,207	2,479	7,686		25
26	Insurance-Prop.Liab.Malpractice			25,724	25,724		25,724	657	26,381		26
27	Other (specify):* <u>Home Office Ben. Allocation</u>										27
28	TOTAL General Administration	24,640	2,794	382,827	410,261		410,261	(25,034)	385,227		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,094,850	224,872	573,482	1,893,204		1,893,204	(27,878)	1,865,326		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

Shelbyville Rehabilitation & Health Care Center

#0053066

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			48,297	48,297		48,297	7,967	56,264			30
31	Amortization of Pre-Op. & Org.							5,267	5,267			31
32	Interest							35,152	35,152			32
33	Real Estate Taxes			32,296	32,296		32,296	199	32,495			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			49,488	49,488		49,488	1,051	50,539			35
36	Other (specify):*											36
37	TOTAL Ownership			130,081	130,081		130,081	49,636	179,717			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		28,336		28,336		28,336		28,336			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			132,163	132,163		132,163		132,163			42
43	Other (specify):*	7,740	190	42,815	50,745		50,745	(50,745)				43
44	TOTAL Special Cost Centers	7,740	28,526	174,978	211,244		211,244	(50,745)	160,499			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,102,590	253,398	878,541	2,234,529		2,234,529	(28,987)	2,205,542			45

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

Shelbyville Rehabilitation & Health Care Center

ID# 0053066

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Labs-Part A	\$ (1,312)	43	1
2	X-Rays-Part A	(319)	43	2
3	Disallowed Marketing Salaries	(7,740)	43	3
4	Offset Transportation Revenue	(4,596)	11	4
5	Offset Miscellaneous Office Supplies Revenue	(57)	21	5
6	Disallowed Special Events	(658)	43	6
7	Offset Security Deposit Refund	(1,351)	5	7
8	Offset Miscellaneous Nursing Supplies Revenue	(592)	10	8
9				9
10				10
11				11
12				12
13				13
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39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(16,625)		49

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	1 Dietary	\$	Petersen Health Care Management, Inc.	100.00%	\$ 3,459	\$ 3,459	1
2	V	2 Food		Petersen Health Care Management, Inc.	100.00%	15	15	2
3	V	3 Housekeeping		Petersen Health Care Management, Inc.	100.00%	52	52	3
4	V	5 Utilities		Petersen Health Care Management, Inc.	100.00%	182	182	4
5	V	6 Maintenance		Petersen Health Care Management, Inc.	100.00%	1,634	1,634	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%	48	48	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	200,500	Petersen Health Care Management, Inc.	100.00%	62,800	(137,700)	11
12	V	19 Professional Services		Petersen Health Care Management, Inc.	100.00%	10,831	10,831	12
13	V							13
14	Total		\$ 200,500			\$ 79,021	\$ * (121,479)	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%	\$ 81	\$	81	15
16	V	21 Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	37,223		37,223	16
17	V	22 Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	16,743		16,743	17
18	V	23 Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	103		103	18
19	V	24 Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	51		51	19
20	V	25 Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	2,479		2,479	20
21	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	657		657	21
22	V	30 Depreciation		Petersen Health Care Management, Inc.	100.00%	8,864		8,864	22
23	V	31 Amortization		Petersen Health Care Management, Inc.	100.00%	80		80	23
24	V	32 Interest		Petersen Health Care Management, Inc.	100.00%	288		288	24
25	V	33 Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	199		199	25
26	V	35 Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	1,051		1,051	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		\$			\$ 67,819	\$ *	67,819	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1 Dietary	\$	Petersen Health Wellness, LLC	100.00%	\$ 0	\$	15	
16	V	2 Food		Petersen Health Wellness, LLC	100.00%	0		16	
17	V	3 Housekeeping		Petersen Health Wellness, LLC	100.00%	0		17	
18	V	4 Laundry		Petersen Health Wellness, LLC	100.00%	0		18	
19	V	5 Utilities		Petersen Health Wellness, LLC	100.00%	0		19	
20	V	6 Maintenance		Petersen Health Wellness, LLC	100.00%	0		20	
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Wellness, LLC	100.00%	0		21	
22	V	10 Nursing and Medical Records		Petersen Health Wellness, LLC	100.00%	0		22	
23	V	15 Mgmt. Allocation of Benefits		Petersen Health Wellness, LLC	100.00%	0		23	
24	V	17 Administrative		Petersen Health Wellness, LLC	100.00%	0		24	
25	V	19 Professional Services		Petersen Health Wellness, LLC	100.00%	44,555	44,555	25	
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Wellness, LLC	100.00%	0		26	
27	V	21 Clerical and General Office		Petersen Health Wellness, LLC	100.00%	0		27	
28	V	22 Employee Benefits & Payroll		Petersen Health Wellness, LLC	100.00%	0		28	
29	V	23 Inservice Training & Education		Petersen Health Wellness, LLC	100.00%	0		29	
30	V	24 Travel and Seminar		Petersen Health Wellness, LLC	100.00%	0		30	
31	V	25 Other Admin. Staff Transport.		Petersen Health Wellness, LLC	100.00%	0		31	
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Wellness, LLC	100.00%	0		32	
33	V	30 Depreciation		Petersen Health Wellness, LLC	100.00%	0		33	
34	V	31 Amortization		Petersen Health Wellness, LLC	100.00%	5,187	5,187	34	
35	V	32 Interest		Petersen Health Wellness, LLC	100.00%	34,864	34,864	35	
36	V	33 Real Estate Taxes		Petersen Health Wellness, LLC	100.00%	0		36	
37	V	34 Rent-Facility and Grounds		Petersen Health Wellness, LLC	100.00%	0		37	
38	V	35 Rent-Equipment & Vehicles		Petersen Health Wellness, LLC	100.00%	0		38	
39	Total		\$			\$ 84,606	\$ *	84,606	39

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

Facility Name & ID Number

Shelbyville Rehabilitation & Health Care Center

0053066

Report Period Beginning:

1/1/2017

Ending: 12/31/2017

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Aledo Health Care Center	Aledo	Petersen Companies, I	Peoria	Mgmt/Bookkeeping	1
2			Arcola Health Care Center	Arcola	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	2
3			Aspen Rehab & Health Care	Silvis	Petersen Health Care,	Peoria	Mgmt/Bookkeeping	3
4			Batavia Rehab & Health Care Center	Batavia	Petersen Health Enter	Peoria	Mgmt/Bookkeeping	4
5			Bement Health Care Center	Bement	Petersen Health Opera	Peoria	Mgmt/Bookkeeping	5
6			Benton Rehab & Health Care Center	Benton	Petersen Health System	Peoria	Mgmt/Bookkeeping	6
7			Bloomington Rehab & Health Care Center	Bloomington	Petersen Hotels LLC	Peoria	Hospitality	7
8			Casey Health Care Center	Casey	Petersen Hospitality L	Peoria	Hospitality	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Management	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Busine	Peoria	Mgmt/Bookkeeping	11
12			Countryview Terrace	Louisville	Petersen Health Care	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care	Peoria	Lessor	13
14			Decatur Rehab & Health Care Center	Decatur	Midwest Health Opera	Peoria	Mgmt/Bookkeeping	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Health Prope	Peoria	Mgmt/Bookkeeping	15
16			Eastview Terrace	Sullivan	Petersen Roseville, LL	Roseville	Lessor	16
17			El Paso Health Care Center	El Paso	Petersen Health Juncti	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Petersen Health Qualit	Peoria	Mgmt/Bookkeeping	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Health and W	Peoria	Mgmt/Bookkeeping	19
20			Flanagan Rehab & Health Care Center	Flanagan	Petersen 24, LLC	Peoria	Hospitality	20
21			Flora Gardens Care Center	Flora				21
22			Flora Health Care Center	Flora				22
23			Fondulac Rehab & Health Care Center	East Peoria				23
24			Havana Health Care Center	Havana				24
25			Illini Heritage Rehab & Health Care	Champaign				25
26			Jonesboro Rehab & Health Care Center	Jonesboro				26
27			Kewanee Care Home	Kewanee				27
28			LaHarpe Davier Health Care Center	LaHarpe				28
29			Lebanon Care Center	Lebanon				29
30			Marigold Rehab & Health Care Center	Galesburg				30

Facility Name & ID Number

Shelbyville Rehabilitation & Health Care Center

0053066

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

Shelbyville Rehabilitation & Health Care Center

0053066

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 Shelbyville Rehabilitation & Health Care Ce # 0053066 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 Shelbyville Rehabilitation & Health Care Center # 0053066 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	15,406	\$ 3,459	1
2	2	Food	Resident Days	1,451,714	75	1,404	0	15,406	15	2
3	3	Housekeeping	Resident Days	1,451,714	75	4,904	2,743	15,406	52	3
4	5	Utilities	Resident Days	1,451,714	75	17,131	0	15,406	182	4
5	6	Maintenance	Resident Days	1,451,714	75	153,997	146,594	15,406	1,634	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,451,714	75	0	0	15,406	0	6
7	9	Medical Director	Resident Days	1,451,714	75	0	0	15,406	0	7
8	10	Nursing and Medical Records	Resident Days	1,451,714	75	4,528	1,833,909	15,406	48	8
9	10A	Therapy	Resident Days	1,451,714	75	0	0	15,406	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,451,714	75	0	0	15,406	0	10
11	17	Administrative	Resident Days	1,451,714	75	4,871,788	5,558,349	15,406	62,800	11
12	19	Professional Services	Resident Days	1,451,714	75	1,020,623	0	15,406	10,831	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,451,714	75	7,613	0	15,406	81	13
14	21	Clerical and General Office	Resident Days	1,451,714	75	3,507,569	3,782,761	15,406	37,223	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,451,714	75	1,577,706	0	15,406	16,743	15
16	23	Inservice Training & Education	Resident Days	1,451,714	75	9,731	0	15,406	103	16
17	24	Travel and Seminar	Resident Days	1,451,714	75	4,833	0	15,406	51	17
18	25	Other Admin. Staff Transport.	Resident Days	1,451,714	75	233,560	0	15,406	2,479	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,451,714	75	61,886	0	15,406	657	19
20	30	Depreciation	Resident Days	1,451,714	75	835,302	0	15,406	8,864	20
21	31	Amortization	Resident Days	1,451,714	75	7,526	0	15,406	80	21
22	32	Interest	Resident Days	1,451,714	75	27,155	0	15,406	288	22
23	33	Real Estate Taxes	Resident Days	1,451,714	75	18,716	0	15,406	199	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,451,714	75	99,030	0	15,406	1,051	24
25	TOTALS					\$ 12,790,903	\$ 11,700,485		\$ 146,840	25

Facility Name & ID Number Shelbyville Rehabilitation & Health Care Center# 0053066

Report Period Beginning:

1/1/2017Ending: 2/31/2017

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Petersen Health Wellness, LLC

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309)691-8113

Fax Number

(309)691-8622

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	94,618	7	\$	\$	15,406	\$	1
2	2	Food	Resident Days	94,618	7			15,406		2
3	3	Housekeeping	Resident Days	94,618	7			15,406		3
4	4	Laundry	Resident Days	94,618	7			15,406		4
5	5	Utilities	Resident Days	94,618	7			15,406		5
6	6	Maintenance	Resident Days	94,618	7			15,406		6
7	7	Mgmt. Allocation of Benefits	Resident Days	94,618	7			15,406		7
8	10	Nursing and Medical Records	Resident Days	94,618	7			15,406		8
9	15	Mgmt. Allocation of Benefits	Resident Days	94,618	7			15,406		9
10	17	Administrative	Resident Days	94,618	7			15,406		10
11	19	Professional Services	Resident Days	94,618	7	273,643		15,406	44,555	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	94,618	7			15,406		12
13	21	Clerical and General Office	Resident Days	94,618	7			15,406		13
14	22	Employee Benefits & Payroll	Resident Days	94,618	7			15,406		14
15	23	Inservice Training & Education	Resident Days	94,618	7			15,406		15
16	24	Travel and Seminar	Resident Days	94,618	7			15,406		16
17	25	Other Admin. Staff Transport.	Resident Days	94,618	7			15,406		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	94,618	7			15,406		18
19	30	Depreciation	Resident Days	94,618	7			15,406		19
20	31	Amortization	Resident Days	94,618	7	31,854		15,406	5,187	20
21	32	Interest	Resident Days	94,618	7	214,122		15,406	34,864	21
22	33	Real Estate Taxes	Resident Days	94,618	7			15,406		22
23	34	Rent-Facility and Grounds	Resident Days	94,618	7			15,406		23
24	35	Rent-Equipment & Vehicles	Resident Days	94,618	7			15,406		24
25	TOTALS					\$ 519,619	\$		\$ 84,606	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1		X																		
2																				
3																				
4																				
5																				
Working Capital																				
6																				
7																				
8																				
9	TOTAL Facility Related																			
B. Non-Facility Related*																				
10																				
11																				
12																				
13																				
14	TOTAL Non-Facility Related																			
15	TOTALS (line 9+line14)																			

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

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

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

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2016 report.		\$	<u>32,808</u>	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	<u>32,068</u>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>(740)</u>	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>33,036</u>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	Home Office Allocation	\$	<u>199</u>	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<u>32,495</u>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2012	<u>31,046</u>	8
	2013	<u>31,102</u>	9
	2014	<u>31,369</u>	10
	2015	<u>31,854</u>	11
	2016	<u>32,068</u>	12

Accrual based on prior year tax bill.

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

NOTES:

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

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Shelbyville Rehabilitation & Health Care Center COUNTY Shelby
 FACILITY IDPH LICENSE NUMBER 0053066
 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)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>1812-13-01-103-005</u>	<u>Long-Term Care Facility</u>	\$ <u>32,068.24</u>	\$ <u>32,068.24</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>32,068.24</u></u>	\$ <u><u>32,068.24</u></u>

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 Shelbyville Rehabilitation & Health Care Center

0053066 Report Period Beginning:

1/1/2017 Ending:

12/31/2017

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 16,099 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

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

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

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

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

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

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

N/A

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

1. Total Amount Incurred: 188,175 2. Number of Years Over Which it is Being Amortized: 20
3. Current Period Amortization: 5,267 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>80,150</u>	<u>2005</u>	<u>\$ 47,250</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	80,150		\$ 47,250	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	80	2005	1971	\$ 870,750	\$	25	\$ 35,230	\$ 34,053	\$ 429,875	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Sidewalks		2006	6,365		15	424	424	4,876	9
10	Building Repair (Wind Damage)		2007	4,308		15	287	287	3,014	10
11	Sprinkler Installation		2008	5,990		7			5,990	11
12	Sprinkler System Repair		2009	7,455		7			7,455	12
13	Dry Pipe Valve Repair		2010	3,869		7	281	281	3,869	13
14	Sprinkler Line Repair		2010	4,106		7	297	297	4,106	14
15	Sprinkler Replacement		2011	17,599		15	1,174	1,174	7,044	15
16	Water Heater-100 Gallon		2013	5,850		7	836	836	3,762	16
17	Sidewalks		2013	4,850		15	324	324	1,458	17
18	Compressor and Piping Repair		2014	5,741		7	820	820	2,870	18
19	Water Heater-76 Gallon		2015	3,813		7	545	545	1,362	19
20	Alarm System Replacement		2015	3,846		7	550	550	1,375	20
21	Flooring in Hallway		2017	4,000		15	133	133	133	21
22	Kitchen Cabinet Replacement		2017	3,000		7	214	214	214	22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30	Land Improvements Booked				1,424			(1,424)		30
31	Building Booked				34,256			(34,256)		31
32	Building Improvement Booked				8,279			(8,279)		32
33										33
34	2017-Home Office Allocation-Building Improvements			7,047			169	169		34
35	2017-Home Office Allocation-Land Improvements			648			42	42		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)	\$ 959,237	\$ 43,959		\$ 41,326	\$ (3,810)	\$ 477,403	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 62,848	\$ 4,338	\$ 6,285	\$ 1,947	5-10 yrs.	\$ 40,545	71
72	Current Year Purchases					7 yrs.		72
73	Fully Depreciated Assets	181,719					181,719	73
74	Home Office Allocation			8,653	8,653			74
75	TOTALS	\$ 244,567	\$ 4,338	\$ 14,938	\$ 10,600		\$ 222,264	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,251,054	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 48,297	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 56,264	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 7,967	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 699,667	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 Shelbyville Rehabilitation & Health Care Center

0053066

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.

YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

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

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 45,914 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	Vehicle	2012 Ford E150	\$ 578.17	\$ 4,625	17
18					18
19					19
20					20
21	TOTAL		\$ 578.17	\$ 4,625	21

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

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

**Shelbyville Rehabilitation & Health Care Center
0053066**

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	\$ 35,237
Dishwasher	701
Generator	44
Copier	8,881
Home Office Allocation	1,051
	<u>45,914</u>

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	2,367	\$ 35,498	\$	2,367	\$ 35,498	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		936	14,033		936	14,033	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		2,983	44,738	152	2,983	44,890	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescripts				28,336		28,336	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____									13
14	TOTAL			\$	6,286	\$ 94,269	\$ 28,488	6,286	\$ 122,757	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.

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 258,349	\$ 258,349	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>62,169</u>)	438,515	438,515	3
4	Supply Inventory (priced at <u>Cost</u>)	6,592	6,592	4
5	Short-Term Investments			5
6	Prepaid Insurance	17,452	17,452	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	23,962	23,962	8
9	Other(specify): <u>Employee Education Loans</u>	785	785	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 745,655	\$ 745,655	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	68,615	47,250	13
14	Buildings, at Historical Cost	855,750	877,797	14
15	Leasehold Improvements, at Historical Cost	116,083	81,440	15
16	Equipment, at Historical Cost	244,567	244,567	16
17	Accumulated Depreciation (book methods)	(716,227)	(699,667)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Intercompany Loans</u>	2,793	2,793	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 571,581	\$ 554,180	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,317,236	\$ 1,299,835	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 403,408	\$ 403,408	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	51,840	51,840	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,028	2,028	31
32	Accrued Real Estate Taxes(Sch.IX-B)	33,036	33,036	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	31,083	31,083	36
37	<u>Accrued Management Fees</u>	200,733	200,733	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 722,128	\$ 722,128	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 722,128	\$ 722,128	46
47	TOTAL EQUITY(page 18, line 24)	\$ 595,108	\$ 577,707	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,317,236	\$ 1,299,835	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 300,680	1
2	Restatements (describe):		2
3	Adjustments Made After Cost Report Was Filed	4,498	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 305,178	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	289,930	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)	\$ 289,930	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)	\$ 595,108	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Shelbyville Rehabilitation & Health Care Center

0053066

Report Period Beginning: 1/1/2017

Ending:

12/31/2017

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

I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,370,368	1
2	Discounts and Allowances for all Levels	(117,623)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,252,745	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	182,672	6
7	Oxygen	1,237	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 183,909	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,695	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	58,507	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	3,849	20
21	Other Medical Services	17,070	21
22	Laundry	88	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 81,209	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Transportation Revenue</u>	4,596	28
28a	<u>Miscellaneous Revenue</u>	2,000	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 6,596	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,524,459	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	440,514	31
32	Health Care	1,042,429	32
33	General Administration	410,261	33
B. Capital Expense			
34	Ownership	130,081	34
C. Ancillary Expense			
35	Special Cost Centers	79,081	35
36	Provider Participation Fee	132,163	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,234,529	40
41	Income before Income Taxes (line 30 minus line 40)**	289,930	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 289,930	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,653,249	44
45	Private Pay - Net Inpatient Revenue	421,063	45
46	Medicare - Net Inpatient Revenue	152,966	46
47	Other-(specify) <u>Insurance Net Inpatient Revenue</u>	25,467	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,252,745	49

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

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

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

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

Facility Name & ID Number Shelbyville Rehabilitation & Health Care Center

0053066

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	2,679	2,913	\$ 68,510	\$ 23.52	1
2	Assistant Director of Nursing					2
3	Registered Nurses	909	909	27,368	30.11	3
4	Licensed Practical Nurses	15,499	15,898	299,373	18.83	4
5	CNAs & Orderlies	24,431	24,827	341,056	13.74	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,095	1,184	13,363	11.29	9
10	Activity Assistants	120	120	1,051	8.76	10
11	Social Service Workers	2,027	2,035	21,208	10.42	11
12	Dietician					12
13	Food Service Supervisor	2,723	2,867	35,846	12.50	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,063	8,284	76,688	9.26	15
16	Dishwashers					16
17	Maintenance Workers	2,080	2,080	30,215	14.53	17
18	Housekeepers	7,955	8,052	85,631	10.63	18
19	Laundry	80	80	876	10.95	19
20	Administrator	2,080	2,080	62,800	30.19	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,911	1,961	24,640	12.57	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 Care(specify)					32
33	Other(specify) <u>See PG20A</u>	4,246	4,505	76,765	17.04	33
34	TOTAL (lines 1 - 33)	75,898	77,795	\$ 1,165,390 *	\$ 14.98	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$		35
36	Medical Director	Monthly 12,000	L9,C3	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 4,068	L10, C3	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant	10 472	L10A, C3	42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	10 \$ 16,540		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

Shelbyville Rehabilitation & Health Care Center

0053066

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	1,859	1,891	42,027	22.22
Transportation	1,913	2,052	26,998	13.16
Marketing	474	562	7,740	13.77
TOTAL	<u>4,246</u>	<u>4,505</u>	<u>76,765</u>	

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	
Valerie Tischler	Administrator	0	\$ 62,800	Workers' Compensation Insurance	\$ 29,035	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance	14,956	Advertising: Employee Recruitment		
				FICA Taxes	78,451	Health Care Worker Background Check		
				Employee Health Insurance	(25)	(Indicate # of checks performed 155)	716	
				Employee Meals		Miscellaneous Licenses & Permits	408	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Dues & Subscriptions	952	
				Employee Relations	2,094	Home Office Allocation	81	
				Employee Retirement	7			
				Home Office Allocation	16,743			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 62,800	TOTAL (agree to Schedule V, line 22, col.8)		\$ 4,147		
B. Administrative - Other							Less: Public Relations Expense ()	
Description			Amount				Non-allowable advertising ()	
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 200,500				Yellow page advertising ()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 200,500				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
Ability Network	Computer Services		\$ 4,567				Out-of-State Travel	\$
Consolidated Communications	Computer Services		1,161					
Honkamp Krueger & Co.	Accounting Services		685					
Allscripts	Computer Services		888	N/A			In-State Travel	
Regions Bank	Legal Fees		60					
Community Bank of Shelby Co.	Legal Fees		100					
ProTitle USA	Legal Fees		195				Seminar Expense	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 7,656	TOTAL		\$	Home Office Allocation	51
							Entertainment Expense ()	
							TOTAL (agree to Sch. V, line 24, col. 8)	
							\$ 51	

* Attach copy of IMRF notifications

**See instructions.

Shelbyville Rehabilitation & Health Care Center**0053066****Period Beginning****1/1/2017****Period End****12/31/2017****Schedule 21A****XIX. SUPPORT SCHEDULE****C. Professional Services**

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		7,656
Home Office Allocation		
MusilloUnkenholt, LLC	Legal	124
Arnstein & Lehr	Legal	832
SB2	Legal	523
Miscellaneous	Legal	10
Miller Hall and Triggs	Legal	132
Smith Amundsen	Legal	51
Healthcare Resources International	Legal	92
Hunziker Law	Legal	1
Lexis Nexis	Legal	5
Baker Tilly Virchow Krause	Legal	464
Gemino	Legal	1328
CliftonLarsonAllen	Accounting	1486
Ginoli & Co.	Accounting	3026
Baker Tilly Virchow Krause	Accounting	93
Gemino	Accounting	8063
Miscellaneous	Computer Services	67
Change Healthcare	Computer Services	6
360 Networks	Computer Services	28
Matrix Care	Computer Services	2592
Stratus Networks	Computer Services	310
Kemper Technology	Computer Services	176
AT&T	Computer Services	4
Ability Network	Computer Services	191
CIAN	Computer Services	216
Comcast	Computer Services	12
CCH	Computer Services	11
Charter Communications	Computer Services	22
Allscripts	Computer Services	192
ATS	Computer Services	197
Citrix Systems	Computer Services	18
Optimizer	Other Prof Fees	35
Ankura	Other Prof Fees	558
David Budde	Other Prof Fees	26
Sargent Consulting	Other Prof Fees	9692
Alix Partners	Other Prof Fees	23771
Demonica Kemper	Other Prof Fees	23
Brad Barkley	Other Prof Fees	91
MPAC Healthcare	Other Prof Fees	14
Higgs Appraisal	Other Prof Fees	6
Alan Litwiller	Other Prof Fees	2
Gemino	Other Prof Fees	896
Total (agree to Schedule V, line 19, column 8)		<u><u>63,042</u></u>

Facility Name & ID Number Shelbyville Rehabilitation & Health Care Center# 0053066Report Period Beginning: 1/1/2017Ending: 12/31/2017**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IHCA-\$952
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 14,264 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. \$ 132,163
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,695
- (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. \$ 4,596
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