		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.

2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

I. IDPH License ID Number: 0053470

Facility Name: Collinsville Rehabilitation & Health Care Center

Address: 614 North Summit (Number) Collinsville (City) 62234 (Zip Code)

County: Madison

Telephone Number: (618) 344-8476 **Fax #** (618) 344-8483

HFS ID Number:

Date of Initial License for Current Owners: 07/25/2006

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 1/1/2018 to 12/31/2018 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 Collinsville Rehabilitation & Health Care Center # 0053470 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	98	Skilled (SNF)	98	35,770	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	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	21,654	445	1,537	23,636	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,654	445	1,537	23,636	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.08%

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 [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 7/25/2006

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 7/25/2006 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 98 and days of care provided 1,415

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2018 Fiscal Year: 12/31/2018

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

Facility Name & ID Number Collinsville Rehabilitation & Health Care Cer # 0053470 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	118,272	15,979		134,251		134,251	5,740	139,991			1
2	Food Purchase		143,511		143,511		143,511	(323)	143,188			2
3	Housekeeping	143,154	24,886		168,040		168,040	91	168,131			3
4	Laundry		9,878		9,878		9,878	640	10,518			4
5	Heat and Other Utilities			73,559	73,559		73,559	293	73,852			5
6	Maintenance	49,218	8,700	12,076	69,994		69,994	2,251	72,245			6
7	Other (specify):* Home Office Ben. Allocation											7
8	**TOTAL General Services**	310,644	202,954	85,635	599,233		599,233	8,692	607,925			8
	B. Health Care and Programs											
9	Medical Director			14,400	14,400		14,400		14,400			9
10	Nursing and Medical Records	1,057,281	85,373	7,327	1,149,981		1,149,981	10,312	1,160,293			10
10a	Therapy			243,095	243,095		243,095		243,095			10a
11	Activities	39,934	568	336	40,838		40,838	(6,096)	34,742			11
12	Social Services	37,349			37,349		37,349		37,349			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Office Ben. Allocation											15
16	**TOTAL Health Care and Programs**	1,134,564	85,941	265,158	1,485,663		1,485,663	4,216	1,489,879			16
	C. General Administration											
17	Administrative			260,300	260,300		260,300	(177,584)	82,716			17
18	Directors Fees											18
19	Professional Services			28,317	28,317		28,317	26,237	54,554			19
20	Dues, Fees, Subscriptions & Promotions			4,255	4,255		4,255	5,842	10,097			20
21	Clerical & General Office Expenses	22,347	2,890	15,849	41,086		41,086	58,653	99,739			21
22	Employee Benefits & Payroll Taxes			152,817	152,817		152,817	25,468	178,285			22
23	Inservice Training & Education							144	144			23
24	Travel and Seminar							3	3			24
25	Other Admin. Staff Transportation			7,110	7,110		7,110	4,370	11,480			25
26	Insurance-Prop.Liab.Malpractice			30,215	30,215		30,215	1,096	31,311			26
27	Other (specify):* Home Office Ben. Allocation											27
28	**TOTAL General Administration**	22,347	2,890	498,863	524,100		524,100	(55,771)	468,329			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,467,555	291,785	849,656	2,608,996		2,608,996	(42,863)	2,566,133			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 Collinsville Rehabilitation & Health Care Center #0053470 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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			85,497	85,497		85,497	3,166	88,663			30
31	Amortization of Pre-Op. & Org.							8,843	8,843			31
32	Interest			156,112	156,112		156,112	44,902	201,014			32
33	Real Estate Taxes			39,724	39,724		39,724	434	40,158			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			26,984	26,984		26,984	1,262	28,246			35
36	Other (specify):*											36
37	**TOTAL Ownership**			308,317	308,317		308,317	58,607	366,924			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		31,708		31,708		31,708		31,708			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			187,735	187,735		187,735		187,735			42
43	Other (specify):* **Miscellaneous**		157	92,851	93,008		93,008	(93,008)				43
44	**TOTAL Special Cost Centers**		31,865	280,586	312,451		312,451	(93,008)	219,443			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,467,555	323,650	1,438,559	3,229,764		3,229,764	(77,264)	3,152,500			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 Collinsville Rehabilitation & Health Care Center # 0053470 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(377)	2		4
5	Telephone, TV & Radio in Resident Rooms	(12,615)	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	(10,765)	30		9
10	Interest and Other Investment Income	(5,876)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(32)	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	(27,373)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(4,000)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(48,000)	43		24
25	Fund Raising, Advertising and Promotional	(496)	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	(11,968)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (121,502)		$	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)	44,238	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 44,238		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (77,264)		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

Collinsville Rehabilitation & Health Care Center

ID# 0053470

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs-Part A	$ (3,683)	43	1
2	X-Rays-Part A	(609)	43	2
3	Offset Transportation Revenue	(6,096)	11	3
4	Offset Miscellaneous Office Supplies Revenue	(250)	21	4
5	Disllowed Special Events	(200)	43	5
6	Offset Miscellaneous Nursing Supplies Revenue	(1,130)	10	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
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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**	(11,968)		49

Facility Name & ID Number Collinsville Rehabilitation & Health Care Center # 0053470 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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. [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)	
1	V	1	Dietary	$	Petersen Health Care Management, Inc.	100.00%	$ 5,740	$ 5,740	1
2	V	2	Food		Petersen Health Care Management, Inc.	100.00%	54	54	2
3	V	3	Housekeeping		Petersen Health Care Management, Inc.	100.00%	91	91	3
4	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	293	293	4
5	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	2,251	2,251	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%	3,973	3,973	8
9	V	10A	Therapy		Petersen Health Care Management, Inc.	100.00%	0		9
10	V	15	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		10
11	V	17	Administrative	188,300	Petersen Health Care Management, Inc.	100.00%	82,716	(105,584)	11
12	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	17,375	17,375	12
13	V								13
14	Total			$ 188,300			$ 112,493	$ * (75,807)	14

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

Facility Name & ID Number Collinsville Rehabilitation & Health Care Center # 0053470 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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%	$ 4,258	$ 4,258	15
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	58,903	58,903	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	24,739	24,739	17
18	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	144	144	18
19	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	3	3	19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	4,370	4,370	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	1,096	1,096	21
22	V	27	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	13,931	13,931	22
23	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	126	126	23
24	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	3,663	3,663	24
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	434	434	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	1,262	1,262	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			$			$ 112,929	$ * 112,929	39

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

Facility Name & ID Number Collinsville Rehabilitation & Health Care Center # 0053470 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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 Business, LLC	100.00%	$ 0	$	15
16	V	2	Food		Petersen Health Business, LLC	100.00%	0		16
17	V	3	Housekeeping		Petersen Health Business, LLC	100.00%	0		17
18	V	4	Laundry		Petersen Health Business, LLC	100.00%	640	640	18
19	V	5	Utilities		Petersen Health Business, LLC	100.00%	0		19
20	V	6	Maintenance		Petersen Health Business, LLC	100.00%	0		20
21	V	7	Mgmt. Allocation of Benefits		Petersen Health Business, LLC	100.00%	0		21
22	V	10	Nursing and Medical Records		Petersen Health Business, LLC	100.00%	7,469	7,469	22
23	V	15	Mgmt. Allocation of Benefits		Petersen Health Business, LLC	100.00%	0		23
24	V	17	Administrative	72,000	Petersen Health Business, LLC	100.00%	0	(72,000)	24
25	V	19	Professional Services		Petersen Health Business, LLC	100.00%	12,862	12,862	25
26	V	20	Dues, Fees, Subs & Promotions		Petersen Health Business, LLC	100.00%	1,584	1,584	26
27	V	21	Clerical and General Office		Petersen Health Business, LLC	100.00%	0		27
28	V	22	Employee Benefits & Payroll		Petersen Health Business, LLC	100.00%	729	729	28
29	V	23	Inservice Training & Education		Petersen Health Business, LLC	100.00%	0		29
30	V	24	Travel and Seminar		Petersen Health Business, LLC	100.00%	0		30
31	V	25	Other Admin. Staff Transport.		Petersen Health Business, LLC	100.00%	0		31
32	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Business, LLC	100.00%	0		32
33	V	30	Depreciation		Petersen Health Business, LLC	100.00%	0		33
34	V	31	Amortization		Petersen Health Business, LLC	100.00%	8,717	8,717	34
35	V	32	Interest		Petersen Health Business, LLC	100.00%	47,115	47,115	35
36	V	33	Real Estate Taxes		Petersen Health Business, LLC	100.00%	0		36
37	V	34	Rent-Facility and Grounds		Petersen Health Business, LLC	100.00%	0		37
38	V	35	Rent-Equipment & Vehicles		Petersen Health Business, LLC	100.00%	0		38
39	Total			$ 72,000			$ 79,116	$ * 7,116	39

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

Facility Name & ID Number Collinsville Rehabilitation & Health Care Center # 0053470 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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 Syster	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 I	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 Busin	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 Collinsville Rehabilitation & Health Care Center # 0053470 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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 Bloomington Rehabilitation & Health Care Center # 0047415 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 Bloomington Rehabilitation & Health Care Center # 0047415 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 Collinsville Rehabilitation & Health Care Ce # 0053470 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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 Collinsville Rehabilitation & Health Care Center # 0053470 Report Period Beginning: 1/1/2018 Ending: 2/31/2018

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	1,411,762	75	$ 342,871	$ 393,211	23,636	$ 5,740	1
2	2	Food	Resident Days	1,411,762	75	3,216	0	23,636	54	2
3	3	Housekeeping	Resident Days	1,411,762	75	5,441	2,652	23,636	91	3
4	5	Utilities	Resident Days	1,411,762	75	17,524	0	23,636	293	4
5	6	Maintenance	Resident Days	1,411,762	75	134,460	148,272	23,636	2,251	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,411,762	75	0	0	23,636	0	6
7	9	Medical Director	Resident Days	1,411,762	75	0	0	23,636	0	7
8	10	Nursing and Medical Records	Resident Days	1,411,762	75	237,275	1,454,984	23,636	3,973	8
9	10A	Therapy	Resident Days	1,411,762	75	0	0	23,636	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,411,762	75	0	0	23,636	0	10
11	17	Administrative	Resident Days	1,411,762	75	4,940,583	5,658,897	23,636	82,716	11
12	19	Professional Services	Resident Days	1,411,762	75	1,037,806	0	23,636	17,375	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,411,762	75	254,355	0	23,636	4,258	13
14	21	Clerical and General Office	Resident Days	1,411,762	75	3,518,216	3,764,024	23,636	58,903	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,411,762	75	1,477,639	0	23,636	24,739	15
16	23	Inservice Training & Education	Resident Days	1,411,762	75	8,601	0	23,636	144	16
17	24	Travel and Seminar	Resident Days	1,411,762	75	174	0	23,636	3	17
18	25	Other Admin. Staff Transport.	Resident Days	1,411,762	75	261,018	0	23,636	4,370	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,411,762	75	65,437	0	23,636	1,096	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,411,762	75	832,087	0	23,636	13,931	20
21	30	Depreciation	Resident Days	1,411,762	75	7,528	0	23,636	126	21
22	32	Interest	Resident Days	1,411,762	75	218,814	0	23,636	3,663	22
23	33	Real Estate Taxes	Resident Days	1,411,762	75	25,901	0	23,636	434	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,411,762	75	75,380	0	23,636	1,262	24
25	TOTALS					$ 13,464,326	$ 11,422,040		$ 225,422	25

Facility Name & ID Number Collinsville Rehabilitation & Health Care Center # 0053470 Report Period Beginning: 1/1/2018 Ending: 2/31/2018

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 Business, 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	150,333	9	$	$	23,636	$	1
2	2	Food	Resident Days	150,333	9			23,636		2
3	3	Housekeeping	Resident Days	150,333	9			23,636		3
4	4	Laundry	Resident Days	150,333	9	4,068		23,636	640	4
5	5	Utilities	Resident Days	150,333	9			23,636		5
6	6	Maintenance	Resident Days	150,333	9			23,636		6
7	7	Mgmt. Allocation of Benefits	Resident Days	150,333	9			23,636		7
8	10	Nursing and Medical Records	Resident Days	150,333	9	47,503		23,636	7,469	8
9	15	Mgmt. Allocation of Benefits	Resident Days	150,333	9			23,636		9
10	17	Administrative	Resident Days	150,333	9			23,636		10
11	19	Professional Services	Resident Days	150,333	9	81,804		23,636	12,862	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	150,333	9	10,073		23,636	1,584	12
13	21	Clerical and General Office	Resident Days	150,333	9			23,636		13
14	22	Employee Benefits & Payroll	Resident Days	150,333	9	4,639		23,636	729	14
15	23	Inservice Training & Education	Resident Days	150,333	9			23,636		15
16	24	Travel and Seminar	Resident Days	150,333	9			23,636		16
17	25	Other Admin. Staff Transport.	Resident Days	150,333	9			23,636		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	150,333	9			23,636		18
19	30	Depreciation	Resident Days	150,333	9			23,636		19
20	31	Amortization	Resident Days	150,333	9	55,441		23,636	8,717	20
21	32	Interest	Resident Days	150,333	9	299,670		23,636	47,115	21
22	33	Real Estate Taxes	Resident Days	150,333	9			23,636		22
23	34	Rent-Facility and Grounds	Resident Days	150,333	9			23,636		23
24	35	Rent-Equipment & Vehicles	Resident Days	150,333	9			23,636		24
25	TOTALS					$ 503,198	$		$ 79,116	25

Facility Name & ID Number Collinsville Rehabilitation & Health Care Ce # 0053470 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	Bank Leumi		X	Mortgage	Varies	1/1/15	$ 1,368,750	$ 1,226,147	12/31/24	Varies	$ 156,112	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 1,368,750	$ 1,226,147			$ 156,112	9
	B. Non-Facility Related*											
10								Interest Income Offset			(5,876)	10
11								Home Office Allocation-PHB			47,115	11
12								Home Office Allocation-PHCM			3,663	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 44,902	14
15	TOTALS (line 9+line14)						$ 1,368,750	$ 1,226,147			$ 201,014	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 Collinsville Rehabilitation & Health Care Center # 0053470 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	48,164	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.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$	(48,164)	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)	$	87,888	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**		434	
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.	$	40,158	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	42,543	8
	2014	43,537	9
	2015	44,110	10
	2016	45,601	11
	2017	43,296	12

Accrual based on prior year tax bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Collinsville Rehabilitation & Health Care Center COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0053470

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 2017 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 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-2-21-28-18-303-001	Long-Term Care Facility	$ 43,295.92	$ 43,295.92
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 43,295.92	$ 43,295.92

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 _____ 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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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 Collinsville Rehabilitation & Health Care Center # 0053470 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 29,350 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: 295,295
2. Number of Years Over Which it is Being Amortized: 5
3. Current Period Amortization: 8,843
4. Dates Incurred: 2010-2012 Home Office Refinancing

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	391,343	2006	$ 40,000	1
2					2
3	TOTALS	391,343		$ 40,000	3

Facility Name & ID Number Collinsville Rehabilitation & Health Care Center # 0053470 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	100		2006	1962	$ 1,635,299	$	30	$ 54,510	$ 54,510	$ 681,375	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Wheelchair Ramp			2007	2,530		15	169	169	1,943	9
10	Fountain			2007	1,269		15	85	85	977	10
11	Exit Signs			2007	612		7			612	11
12	Blinds			2007	4,886		10			4,886	12
13	Exit Signs			2008	690		15	46	46	483	13
14	Boiler			2009	6,500		7			6,500	14
15	Sprinkler Repair			2009	22,880		7			22,880	15
16	Boiler			2010	11,339		15	756	756	8,938	16
17	A/C Unit			2010	6,260		15	418	418	3,553	17
18	Roof Replacement			2010	69,464		25	2,778	2,778	23,613	18
19	Nurse Call Light System			2011	6,260		10	626	626	4,695	19
20	Ceiling Repair			2011	2,575		7	183	183	2,575	20
21	Roof Replacement-Completion of 2010 Work			2011	44,923		25	1,796	1,796	13,470	21
22	Roof Repairs			2012	3,047		7	436	436	2,834	22
23	Roof and Gutter Replacement			2012	64,790		25	2,592	2,592	16,848	23
24	Roof Repairs			2013	9,793		7	1,400	1,400	7,700	24
25	Condensing Unit			2014	4,500		7	643	643	2,894	25
26	Flooring Replacement-Dining Room and Common Area			2015	15,946		15	1,064	1,064	3,724	26
27	Water Heater			2016	4,054		7	580	580	1,450	27
28	Sod Installation			2016	12,903		10	1,290	1,290	3,225	28
29	Water Heater			2017	4,321		7	618	618	927	29
30	Furnace			2018	4,595		15	153	153	153	30
31											31
32											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 Collinsville Rehabilitation & Health Care Center # 0053470 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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			$	$		$	$	$	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	Land Improvements Booked			253			(253)		63
64	Building Booked			65,634			(65,634)		64
65	Building Improvement Booked			16,231			(16,231)		65
66									66
67	2018-Home Office Allocation-Building Improvements		11,117			267	267		67
68	2018-Home Office Allocation-Land Improvements		1,115			71	71		68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,951,668	$ 82,118		$ 70,481	$ (11,637)	$ 816,255	70

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

Facility Name & ID Number Collinsville Rehabilitation & Health Care Center # 0053470 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	$ 37,149	$ 3,379	$ 4,589	$ 1,210	5-10 yrs.	$ 21,535	71
72	Current Year Purchases					7 yrs.		72
73	Fully Depreciated Assets	214,780					214,780	73
74	Home Office Allocation			13,593	13,593			74
75	TOTALS	$ 251,929	$ 3,379	$ 18,182	$ 14,803		$ 236,315	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)	$	2,243,597	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	85,497	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	88,663	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	3,166	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	1,052,570	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	N/A				87
88					88
89					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 Collinsville Rehabilitation & Health Care Center # 0053470 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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.	/2019	$
13.	/2020	$
14.	/2021	$

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: $ 28,246 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.

Collinsville Rehabilitation & Health Care Center
0053470
Period Beginning 1/1/2018
Period End 12/31/2018

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	$ 20,098
Dishwasher	701
Copier	6,185
Home Office Allocation	1,262
	28,246

Facility Name & ID Number Collinsville Rehabilitation & Health Care Center # 0053470 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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.

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A(3)	hrs	$	7,479	$ 112,187	$	7,479	$ 112,187	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2,151	32,269		2,151	32,269	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		6,576	98,639		6,576	98,639	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				31,708		31,708	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):		hrs							12
13	Other (specify):									13
14	TOTAL			$	16,206	$ 243,095	$ 31,708	16,206	$ 274,803	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Collinsville Rehabilitation & Health Care Center # 0053470 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2018 (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	$ (1,720,787)	$ (1,720,787)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 282,122)	2,541,523	2,541,523	3
4	Supply Inventory (priced at Cost)	10,390	10,390	4
5	Short-Term Investments			5
6	Prepaid Insurance	19,016	19,016	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Employee Education Loans	228	228	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 850,370	$ 850,370	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	43,799	40,000	13
14	Buildings, at Historical Cost	1,635,299	1,646,416	14
15	Leasehold Improvements, at Historical Cost	268,913	305,252	15
16	Equipment, at Historical Cost	251,929	251,929	16
17	Accumulated Depreciation (book methods)	(1,174,948)	(1,052,570)	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 (spe Const. in Progress	24,475	24,475	22
23	Other(specify): Intercompany Loans	20,010	20,010	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,069,477	$ 1,235,512	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,919,847	$ 2,085,882	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 604,603	$ 604,603	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	64,121	64,121	30
31	Accrued Taxes Payable (excluding real estate taxes)	288,001	288,001	31
32	Accrued Real Estate Taxes(Sch.IX-B)	87,888	87,888	32
33	Accrued Interest Payable	7,710	7,710	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	684	684	36
37	Accrued Management Fees	614,379	614,379	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,667,386	$ 1,667,386	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,226,147	1,226,147	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)**	$ 1,226,147	$ 1,226,147	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,893,533	$ 2,893,533	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (973,686)	$ (807,651)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,919,847	$ 2,085,882	48

***(See instructions.)**

Facility Name & ID Number Collinsville Rehabilitation & Health Care Center # 0053470 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,506,974)	1
2	Restatements (describe):		2
3	Rounding	(2)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,506,976)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	533,290	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)**	$ 533,290	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)**	$ (973,686)	24 *

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

Facility Name & ID Number Collinsville Rehabilitation & Health Care Center # 0053470 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	$ 3,425,307	1
2	Discounts and Allowances for all Levels	(216,783)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,208,524	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	470,976	6
7	Oxygen	1,758	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 472,734	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	377	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	56,156	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	5,194	20
21	Other Medical Services	6,717	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 68,444	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,876	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 5,876	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Transportation Revenue**	6,096	28
28a	**Miscellaneous Revenue**	1,380	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 7,476	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,763,054	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	599,233	31
32	Health Care	1,485,663	32
33	General Administration	524,100	33
	B. Capital Expense		
34	Ownership	308,317	34
	C. Ancillary Expense		
35	Special Cost Centers	124,716	35
36	Provider Participation Fee	187,735	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,229,764	40
41	**Income before Income Taxes (line 30 minus line 40)****	533,290	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 533,290	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,841,717	44
45	Private Pay - Net Inpatient Revenue	86,416	45
46	Medicare - Net Inpatient Revenue	250,614	46
47	Other-(specify) **Insurance Net Inpatient Revenue**	29,777	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,208,524	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 Collinsville Rehabilitation & Health Care Center # 0053470 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	1,828	1,828	$ 71,962	$ 39.37	1
2	Assistant Director of Nursing	1,560	1,560	40,000	25.64	2
3	Registered Nurses	4,786	4,882	130,654	26.76	3
4	Licensed Practical Nurses	10,406	10,675	245,271	22.98	4
5	CNAs & Orderlies	38,255	39,099	474,305	12.13	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	861	861	12,920	15.01	8
9	Activity Director	1,946	2,010	23,967	11.92	9
10	Activity Assistants					10
11	Social Service Workers	2,080	2,080	37,349	17.96	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	31,389	15.09	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,939	9,314	86,883	9.33	15
16	Dishwashers					16
17	Maintenance Workers	1,901	2,048	49,218	24.03	17
18	Housekeepers	14,899	15,135	143,154	9.46	18
19	Laundry					19
20	Administrator	2,000	2,000	82,716	41.36	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,405	1,483	22,347	15.07	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) Page 20A	3,685	3,749	98,136	26.18	33
34	TOTAL (lines 1 - 33)	96,631	98,804	$ 1,550,271 *	$ 15.69	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	14,400	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,468	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	2	116	L10, 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)	2	$ 20,984		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	17	703	L10, C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	17	$ 703		53

Collinsville Rehabilitation & Health Care Center
0053470
Period Beginning **1/1/2018**
Period End **12/31/2018**

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		2,294	2,294	82,169	35.82
Transportation		1,391	1,455	15,967	10.97
	TOTAL	3,685	3,749	98,136	

Facility Name & ID Number Collinsville Rehabilitation & Health Care Center # 0053470 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
LaWanna Kiefer	Administrator	0	$ 82,716
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 82,716

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 260,300
TOTAL (agree to Schedule V, line 17, col. 3)	$ 260,300
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Sorling Northrup	Legal Fees	$ 17,922
Law Office of Van Lear, Echert	Legal Fees	1,798
Charter Communications	Computer Services	792
DJ Howard and Associates	Appraisal Fees	2,500
Ability Network	Computer Services	1,073
Brittiny Thomas	Settlement	2,202
Smith Amundsen	Legal Fees	1,967
Associated Bank	Legal Filing Fees	26
Regions Bank	Legal Filing Fees	37
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 28,317

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 26,432
Unemployment Compensation Insurance	12,413
FICA Taxes	112,642
Employee Health Insurance	566
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	425
Home Office Allocation	25,468
Employee Retirement	339
TOTAL (agree to Schedule V, line 22, col.8)	$ 178,285

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	$ 1,990
Advertising: Employee Recruitment	885
Health Care Worker Background Check	
(Indicate # of checks performed 20)	599
Patient Background Checks	(235)
Miscellaneous Licenses & Permits	1,016
Home Office Allocation	5,842
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,097

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Home Office Allocation	3
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3

* Attach copy of IMRF notifications

**See instructions.

Collinsville Rehabilitation & Health Care Center
0053470
Period Beginning **1/1/2018**
Period End **12/31/2018**

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		28,317
	Non-Allowable Legal	(4,000)
Home Office Allocation		
Duane Morris	Legal	2375
Sedgwick CMS	Legal	210
SB2	Legal	586
Miscellaneous	Legal	175
Christoper P. Ryan	Legal	186
Saul Ewing Arnstein & Lehr	Legal	832
Healthcare Resources International	Legal	125
Winston & Strawn	Legal	2002
Lexis Nexis	Legal	9
Pretzel & Stouffer	Legal	29
Baker Tilly Virchow Krause	Legal	472
Bank Leumi	Legal	4238
CliftonLarsonAllen	Accounting	1215
Ginoli & Co.	Accounting	431
Duane Morris	Accounting	71
Getzler Henrich & Associates	Accounting	933
Kemper Consulting	Accounting	71
Baker Tilly Virchow Krause	Accounting	491
Ginoli & Co.	Accounting	2425
Miscellaneous	Computer Services	135
Change Healthcare	Computer Services	4
TR Professional	Computer Services	12
Matrix Care	Computer Services	1364
Ability Network	Computer Services	2160
Stratus Networks	Computer Services	528
Kemper Technology	Computer Services	606
AT&T	Computer Services	7
Ungerboeck Software	Computer Services	436
CIAN	Computer Services	190
Comcast	Computer Services	47
CCH	Computer Services	18
Charter Communications	Computer Services	32
Allscripts	Computer Services	614
ATS	Computer Services	285
Citrix Systems	Computer Services	100
Optimizer	Other Prof Fees	55
Sedgwick CLMS	Other Prof Fees	192
David Budde	Other Prof Fees	55
Sargent Consulting	Other Prof Fees	151
Alix Partners	Other Prof Fees	573
Getzler Henrich & Associates	Other Prof Fees	78
Getzler Henrich & Associates	Other Prof Fees	4,717
DFH Capital	Other Prof Fees	1002
Total (agree to Schedule V, line 19, column 8)		54,554

Collinsville Rehabilitation & Health Care Center
0053470
Period Beginning **1/1/2018**
Period End **12/31/2018**

Schedule 21A

XIX. SUPPORT SCHEDULE
Legal Fees

Home Office Allocation-PMC & PHCM		
Duane Morris	Legal	2375
Sedgwick CMS	Legal	210
SB2	Legal	586
Miscellaneous	Legal	175
Christoper P. Ryan	Legal	186
Saul Ewing Arnstein & Lehr	Legal	832
Healthcare Resources International	Legal	125
Winston & Strawn	Legal	2002
Lexis Nexis	Legal	9
Pretzel & Stouffer	Legal	29
Baker Tilly Virchow Krause	Legal	472
Bank Leumi	Legal	4238
Direct Facility Invoices		
Sorling Northrup-B. Thomas Case	8/9/2017	60
Sorling Northrup-B. Thomas Case	12/4/2017	4,671
Sorling Northrup-B. Thomas Case	1/8/2018	2,509
Sorling Northrup-B. Thomas Case	2/9/2018	865
Sorling Northrup-B. Thomas Case	3/8/2018	4,384
Sorling Northrup-B. Thomas Case	4/9/2018	3,845
Assoicated Bank-Legal Filing Fees	4/30/2018	26
Sorling Northrup-B. Thomas Case	5/7/2018	1,588
Brittiny Thomas-Settlement	5/8/2018	2,202
Law Office of Van Lear, Echert-B. Thomas Case	5/8/2018	1,798
Smith Amundsen-Case	8/7/2018	1,967
Regions Bank-Legal Filing Fees	8/29/2018	37
Less Settlement		(4,000)
Total Legal Fees (agree to Schedule V, line 19, column 8)		31,191

Collinsville Rehabilitation & Health Care Center
0053470
Period Beginning 1/1/2018
Period End 12/31/2018

Schedule 21C

25. Administrative and Staff Transportation

Gas	$	1,545
Auto Repairs		1,948
Mileage-Travel		3,617
Home Office Allocation		4,370
		11,480

Facility Name & ID Number Collinsville Rehabilitation & Health Care Center # 0053470 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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-**

(3) Did the nursing home make political contributions or payments to a politica
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. $ **17,558** 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 fo
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 Departmen
during this cost report period. $ **187,735**
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 tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
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. $ **377**

(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 fo
residents? **Yes** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **6,096**
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 othe
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. $

(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
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. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees