

Facility Name & ID Number El Paso Health Care Center

0050914 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	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	123	Skilled (SNF)	123	44,895	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	123	TOTALS	123	44,895	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	31,668	695	502	32,865	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	31,668	695	502	32,865	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.20%

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 10/20/2004

J. Was the facility purchased or leased after January 1, 1978?
YES Date 10/20/2004 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 123 and days of care provided 502

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCURAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES 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 El Paso Health Care Center # 0050914 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 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	188,082	22,511	607	211,200		211,200	7,982	219,182		1
2	Food Purchase		236,022		236,022		236,022	(153)	235,869		2
3	Housekeeping	117,508	28,982		146,490		146,490	127	146,617		3
4	Laundry	54,501	14,035		68,536		68,536		68,536		4
5	Heat and Other Utilities			115,910	115,910		115,910	408	116,318		5
6	Maintenance	53,557	6,425	23,562	83,544		83,544	67,552	151,096		6
7	Other (specify):* <u>Home Office Ben. Allocation</u>										7
8	TOTAL General Services	413,648	307,975	140,079	861,702		861,702	75,916	937,618		8
	B. Health Care and Programs										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	1,201,892	79,324	107,281	1,388,497		1,388,497	2,843	1,391,340		10
10a	Therapy			142,406	142,406		142,406		142,406		10a
11	Activities	115,978	136		116,114		116,114	(30,761)	85,353		11
12	Social Services	118,135	20		118,155		118,155		118,155		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	1,436,005	79,480	267,687	1,783,172		1,783,172	(27,918)	1,755,254		16
	C. General Administration										
17	Administrative			332,500	332,500		332,500	(266,964)	65,536		17
18	Directors Fees										18
19	Professional Services			2,529	2,529		2,529	33,339	35,868		19
20	Dues, Fees, Subscriptions & Promotions			4,019	4,019		4,019	5,921	9,940		20
21	Clerical & General Office Expenses	64,932	2,108	9,950	76,990		76,990	81,822	158,812		21
22	Employee Benefits & Payroll Taxes			205,169	205,169		205,169	34,399	239,568		22
23	Inservice Training & Education			196	196		196	200	396		23
24	Travel and Seminar							4	4		24
25	Other Admin. Staff Transportation			16,713	16,713		16,713	6,076	22,789		25
26	Insurance-Prop.Liab.Malpractice			41,375	41,375		41,375	1,523	42,898		26
27	Other (specify):* <u>Home Office Ben. Allocation</u>										27
28	TOTAL General Administration	64,932	2,108	612,451	679,491		679,491	(103,680)	575,811		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,914,585	389,563	1,020,217	3,324,365		3,324,365	(55,682)	3,268,683		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.

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	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			50,931	50,931		50,931	9,289	60,220		30
31	Amortization of Pre-Op. & Org.							17,383	17,383		31
32	Interest			188,610	188,610		188,610	31,912	220,522		32
33	Real Estate Taxes			66,994	66,994		66,994	603	67,597		33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			17,590	17,590		17,590	1,755	19,345		35
36	Other (specify):*										36
37	TOTAL Ownership			324,125	324,125		324,125	60,942	385,067		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		15,602		15,602		15,602		15,602		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			263,463	263,463		263,463		263,463		42
43	Other (specify):* Miscellaneous	34,781		53,602	88,383		88,383	(88,383)			43
44	TOTAL Special Cost Centers	34,781	15,602	317,065	367,448		367,448	(88,383)	279,065		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,949,366	405,165	1,661,407	4,015,938		4,015,938	(83,123)	3,932,815		45

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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(228)	2		4
5	Telephone, TV & Radio in Resident Rooms	(1,196)	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	(10,082)	30		9
10	Interest and Other Investment Income	(3,111)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(16)	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	(38,687)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(9,000)	43		24
25	Fund Raising, Advertising and Promotional	149	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	(8,733)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (70,904)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(12,219)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (12,219)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (83,123)		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

El Paso Health Care Center

ID# 0050914

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (2,817)	43	1
2	X-Rays-Part A	(779)	43	2
3	Offset Miscellaneous Office Supplies Revenue	(80)	21	3
4	Offset Transportation Revenue	(30,761)	11	4
5	Offset Miscellaneous Nursing Supplies Revenue	(2,681)	10	5
6	Offset Misc.Repairs and Maintenance Revenue	64,422	6	6
7	Resident Flowers	(5)	43	7
8	Offset Marketing Salaries	(34,781)	43	8
9	Offset Special Events	(1,251)	43	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
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18				18
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38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(8,733)		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%	\$ 7,982	\$ 7,982	1
2	V	2 Food		Petersen Health Care Management, Inc.	100.00%	75	75	2
3	V	3 Housekeeping		Petersen Health Care Management, Inc.	100.00%	127	127	3
4	V	5 Utilities		Petersen Health Care Management, Inc.	100.00%	408	408	4
5	V	6 Maintenance		Petersen Health Care Management, Inc.	100.00%	3,130	3,130	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%	5,524	5,524	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	236,500	Petersen Health Care Management, Inc.	100.00%	65,536	(170,964)	11
12	V	19 Professional Services		Petersen Health Care Management, Inc.	100.00%	24,160	24,160	12
13	V							13
14	Total		\$ 236,500			\$ 106,942	\$ * (129,558)	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 <u>Dues, Fees, Subs & Promotions</u>	\$	<u>Petersen Health Care Management, Inc.</u>	100.00%	\$ 5,921	\$	5,921	15
16	V	21 <u>Clerical and General Office</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	81,902		81,902	16
17	V	22 <u>Employee Benefits and Payroll Taxes</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	34,399		34,399	17
18	V	23 <u>Inservice Training & Education</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	200		200	18
19	V	24 <u>Travel and Seminar</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	4		4	19
20	V	25 <u>Other Admin. Staff Transport.</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	6,076		6,076	20
21	V	26 <u>Insurance-Prop./Liab./Malprac.</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	1,523		1,523	21
22	V	30 <u>Depreciation</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	19,371		19,371	22
23	V	31 <u>Amortization</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	175		175	23
24	V	32 <u>Interest</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	5,094		5,094	24
25	V	33 <u>Real Estate Taxes</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	603		603	25
26	V	35 <u>Rent-Equipment & Vehicles</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	1,755		1,755	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		\$			\$ 157,023	\$ *	157,023	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 Network, LLC	100.00%	\$ 0	\$
16	V	2 Food		Petersen Health Network, LLC	100.00%	0	
17	V	3 Housekeeping		Petersen Health Network, LLC	100.00%	0	
18	V	4 Laundry		Petersen Health Network, LLC	100.00%	0	
19	V	5 Utilities		Petersen Health Network, LLC	100.00%	0	
20	V	6 Maintenance		Petersen Health Network, LLC	100.00%	0	
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Network, LLC	100.00%	0	
22	V	10 Nursing and Medical Records		Petersen Health Network, LLC	100.00%	0	
23	V	15 Mgmt. Allocation of Benefits		Petersen Health Network, LLC	100.00%	0	
24	V	17 Administrative	96,000	Petersen Health Network, LLC	100.00%	0	(96,000)
25	V	19 Professional Services		Petersen Health Network, LLC	100.00%	9,179	9,179
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Network, LLC	100.00%	0	
27	V	21 Clerical and General Office		Petersen Health Network, LLC	100.00%	0	
28	V	22 Employee Benefits & Payroll		Petersen Health Network, LLC	100.00%	0	
29	V	23 Inservice Training & Education		Petersen Health Network, LLC	100.00%	0	
30	V	24 Travel and Seminar		Petersen Health Network, LLC	100.00%	0	
31	V	25 Other Admin. Staff Transport.		Petersen Health Network, LLC	100.00%	0	
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Network, LLC	100.00%	0	
33	V	30 Depreciation		Petersen Health Network, LLC	100.00%	0	
34	V	31 Amortization		Petersen Health Network, LLC	100.00%	17,208	17,208
35	V	32 Interest		Petersen Health Network, LLC	100.00%	29,929	29,929
36	V	33 Real Estate Taxes		Petersen Health Network, LLC	100.00%	0	
37	V	34 Rent-Facility and Grounds		Petersen Health Network, LLC	100.00%	0	
38	V	35 Rent-Equipment & Vehicles		Petersen Health Network, LLC	100.00%	0	
39	Total		\$ 96,000			\$ 56,316	\$ * (39,684)

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

Facility Name & ID Number

El Paso Health Care Center

0050914

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

El Paso Health Care Center

0050914

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 El Paso Health Care Center # 0050914 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 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 El Paso Health Care Center

0050914

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 NO

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,411,762	75	\$ 342,871	\$ 393,211	32,865	\$ 7,982	1
2	2	Food	Resident Days	1,411,762	75	3,216	0	32,865	75	2
3	3	Housekeeping	Resident Days	1,411,762	75	5,441	2,652	32,865	127	3
4	5	Utilities	Resident Days	1,411,762	75	17,524	0	32,865	408	4
5	6	Maintenance	Resident Days	1,411,762	75	134,460	148,272	32,865	3,130	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,411,762	75	0	0	32,865	0	6
7	9	Medical Director	Resident Days	1,411,762	75	0	0	32,865	0	7
8	10	Nursing and Medical Records	Resident Days	1,411,762	75	237,275	1,454,984	32,865	5,524	8
9	10A	Therapy	Resident Days	1,411,762	75	0	0	32,865	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,411,762	75	0	0	32,865	0	10
11	17	Administrative	Resident Days	1,411,762	75	4,940,583	5,658,897	32,865	65,536	11
12	19	Professional Services	Resident Days	1,411,762	75	1,037,806	0	32,865	24,160	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,411,762	75	254,355	0	32,865	5,921	13
14	21	Clerical and General Office	Resident Days	1,411,762	75	3,518,216	3,764,024	32,865	81,902	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,411,762	75	1,477,639	0	32,865	34,399	15
16	23	Inservice Training & Education	Resident Days	1,411,762	75	8,601	0	32,865	200	16
17	24	Travel and Seminar	Resident Days	1,411,762	75	174	0	32,865	4	17
18	25	Other Admin. Staff Transport.	Resident Days	1,411,762	75	261,018	0	32,865	6,076	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,411,762	75	65,437	0	32,865	1,523	19
20	30	Depreciation	Resident Days	1,411,762	75	832,087	0	32,865	19,371	20
21	31	Amortization	Resident Days	1,411,762	75	7,528	0	32,865	175	21
22	32	Interest	Resident Days	1,411,762	75	218,814	0	32,865	5,094	22
23	33	Real Estate Taxes	Resident Days	1,411,762	75	25,901	0	32,865	603	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,411,762	75	75,380	0	32,865	1,755	24
25	TOTALS					\$ 13,464,326	\$ 11,422,040		\$ 263,965	25

Facility Name & ID Number El Paso Health Care Center

0050914

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 NO

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

Name of Related Organization Petersen Health Network, 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	230,518	13	\$	\$	32,865	\$	1
2	2	Food	Resident Days	230,518	13			32,865		2
3	3	Housekeeping	Resident Days	230,518	13			32,865		3
4	4	Laundry	Resident Days	230,518	13			32,865		4
5	5	Utilities	Resident Days	230,518	13			32,865		5
6	6	Maintenance	Resident Days	230,518	13			32,865		6
7	7	Mgmt. Allocation of Benefits	Resident Days	230,518	13			32,865		7
8	10	Nursing and Medical Records	Resident Days	230,518	13			32,865		8
9	15	Mgmt. Allocation of Benefits	Resident Days	230,518	13			32,865		9
10	17	Administrative	Resident Days	230,518	13			32,865		10
11	19	Professional Services	Resident Days	230,518	13	64,384		32,865	9,179	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	230,518	13			32,865		12
13	21	Clerical and General Office	Resident Days	230,518	13			32,865		13
14	22	Employee Benefits & Payroll	Resident Days	230,518	13			32,865		14
15	23	Inservice Training & Education	Resident Days	230,518	13			32,865		15
16	24	Travel and Seminar	Resident Days	230,518	13			32,865		16
17	25	Other Admin. Staff Transport.	Resident Days	230,518	13			32,865		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	230,518	13			32,865		18
19	30	Depreciation	Resident Days	230,518	13			32,865		19
20	31	Amortization	Resident Days	230,518	13	120,699		32,865	17,208	20
21	32	Interest	Resident Days	230,518	13	209,925		32,865	29,929	21
22	33	Real Estate Taxes	Resident Days	230,518	13			32,865		22
23	34	Rent-Facility and Grounds	Resident Days	230,518	13			32,865		23
24	35	Rent-Equipment & Vehicles	Resident Days	230,518	13			32,865		24
25	TOTALS					\$ 395,008	\$		\$ 56,316	25

Facility Name & ID Number

El Paso Health Care Center

0050914

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	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	Wells Fargo		X	Mortgage	Varies	1/1/15	\$ 4,130,145	\$ 2,807,773	12/31/2025	Varies	\$ 188,610	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6												6						
7												7						
8												8						
9	TOTAL Facility Related						\$ 4,130,145	\$ 2,807,773			\$ 188,610	9						
B. Non-Facility Related*																		
10									Interest Income Offset		(3,111)	10						
11									Home Office Allocation-PHN		29,929	11						
12									Home Office Allocation-PHCM		5,094	12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ 31,912	14						
15	TOTALS (line 9+line14)						\$ 4,130,145	\$ 2,807,773			\$ 220,522	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.)

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME El Paso Health Care Center COUNTY Woodford

FACILITY IDPH LICENSE NUMBER 0050914

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)	(B)	(C)	(D) <u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to Nursing Home</u>
1. <u>16-04-301-024</u>	<u>Long-Term Care Facility</u>	\$ <u>2,692.02</u>	\$ <u>2,692.02</u>
2. <u>16-04-302-017</u>	<u>Long-Term Care Facility</u>	\$ <u>64,137.44</u>	\$ <u>64,137.44</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>66,829.46</u></u>	\$ <u><u>66,829.46</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 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.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 33,000 B. General Construction Type: Exterior Brick & Block Frame Steel 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: 561,304 2. Number of Years Over Which it is Being Amortized: 20

3. Current Period Amortization: 17,383 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	Facility	202,500	2004	\$ 50,000	1
2					2
3	TOTALS	202,500		\$ 50,000	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	123		2004	1974	\$ 934,850	\$	35	\$ 26,710	\$ 26,710	\$ 351,682	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Sidewalks		2006		7,230		15	482	482	6,025	9
10	Windows		2006		7,500		25	300	300	3,750	10
11	Generator		2007		17,756		15	1,184	1,184	13,616	11
12	Office air conditioner repair		2008		3,125		15	208	208	2,184	12
13	Water Heater		2010		9,172		10	918	918	7,803	13
14	Air Conditioner		2010		7,150		15	476	476	4,046	14
15	Fencing		2011		7,048		25	282	282	2,115	15
16	Chair Rail		2013		3,604		7	514	514	2,827	16
17	Boiler		2014		9,662		15	644	644	2,898	17
18	Air Conditoner		2014		6,500		15	433	433	1,949	18
19	Landscaping		2014		10,246		15	683	683	3,074	19
20	Landscaping		2015		11,928		7	1,704	1,704	5,964	20
21	Air Conditioner		2015		5,829		15	390	390	1,365	21
22	Rooftop A/C/Furnace Combo		2016		16,620		15	1,108	1,108	2,770	22
23	Water Heater		2017		3,028		7	432	432	648	23
24											24
25											25
26											26
27											27
28											28
29											29
30	Land Improvements Booked					282			(282)		30
31	Building Booked					37,457			(37,457)		31
32	Building Improvement Booked					8,584			(8,584)		32
33											33
34	2018-Home Office Allocation-Building Improvements				15,458			371	371		34
35	2018-Home Office Allocation-Land Improvements				1,551			98	98		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 El Paso Health Care Center

0050914

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	\$ 40,440	\$ 4,120	\$ 4,114	\$ (6)	5-10 yrs.	\$ 24,273	71
72	Current Year Purchases	3,728	488	267	(221)	7 yrs.	267	72
73	Fully Depreciated Assets	297,098					297,098	73
74	Home Office Allocation			18,902	18,902			74
75	TOTALS	\$ 341,266	\$ 4,608	\$ 23,283	\$ 18,675		\$ 321,638	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)	\$ 1,469,523	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 50,931	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 60,220	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 9,289	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 734,354	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 El Paso Health Care Center

0050914

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

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	\$ _____

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: \$ 19,345 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.

EI Paso Health Care Center

0050914

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	\$ 13,421
Dishwasher	701
Copier	3,468
Home Office Allocation	1,755
	<u>19,345</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	\$	3,782	\$ 56,728	\$	3,782	\$ 56,728	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,405	21,075		1,405	21,075	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		4,299	64,487		4,299	64,487	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				15,602		15,602	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): <u>Respiratory Therapy</u>	10A(3)			8	116		8	116	13
14	TOTAL			\$	9,494	\$ 142,406	\$ 15,602	9,494	\$ 158,008	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	\$ 3,935,142	\$ 3,935,142	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>129,762</u>)	2,627,391	2,627,391	3
4	Supply Inventory (priced at <u>Cost</u>)	15,035	15,035	4
5	Short-Term Investments			5
6	Prepaid Insurance	25,177	25,177	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Prepaid Mgmt. Fees</u>	4,124	4,124	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,606,869	\$ 6,606,869	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	64,278	50,000	13
14	Buildings, at Historical Cost	934,850	950,308	14
15	Leasehold Improvements, at Historical Cost	112,120	127,949	15
16	Equipment, at Historical Cost	341,266	341,266	16
17	Accumulated Depreciation (book methods)	(928,269)	(734,354)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 524,245	\$ 735,169	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,131,114	\$ 7,342,038	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,104,236	\$ 1,104,236	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	94,898	94,898	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,503	2,503	31
32	Accrued Real Estate Taxes(Sch.IX-B)	68,817	68,817	32
33	Accrued Interest Payable	16,558	16,558	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	69,372	69,372	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,356,384	\$ 1,356,384	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,807,773	2,807,773	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Intercompany Loans</u>	185,653	185,653	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,993,426	\$ 2,993,426	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,349,810	\$ 4,349,810	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,781,304	\$ 2,992,228	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,131,114	\$ 7,342,038	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,069,188	1
2	Restatements (describe):		2
3	<u>Rounding</u>	(1)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,069,187	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	712,117	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)	\$ 712,117	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)	\$ 2,781,304	24 *

* This must agree with page 17, line 47.

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,594,674	1
2	Discounts and Allowances for all Levels	(110,393)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,484,281	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	236,308	6
7	Oxygen	24	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 236,332	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	228	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	24,430	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	4,273	20
21	Other Medical Services	3,415	21
22	Laundry	124	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 32,470	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	3,111	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,111	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Transportation Revenue</u>	30,761	28
28a	<u>Miscellaneous Revenue</u>	(58,900)	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (28,139)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,728,055	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	861,702	31
32	Health Care	1,783,172	32
33	General Administration	679,491	33
B. Capital Expense			
34	Ownership	324,125	34
C. Ancillary Expense			
35	Special Cost Centers	103,985	35
36	Provider Participation Fee	263,463	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,015,938	40
41	Income before Income Taxes (line 30 minus line 40)**	712,117	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 712,117	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 4,323,324	44
45	Private Pay - Net Inpatient Revenue	113,808	45
46	Medicare - Net Inpatient Revenue	47,149	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,484,281	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 El Paso Health Care Center

0050914

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	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,560	2,618	\$ 79,488	\$ 30.36	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,935	9,170	270,813	29.53	3
4	Licensed Practical Nurses	8,389	8,399	217,481	25.89	4
5	CNAs & Orderlies	42,844	44,128	517,138	11.72	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,420	1,468	14,665	9.99	9
10	Activity Assistants	6,913	7,054	62,514	8.86	10
11	Social Service Workers	8,823	8,972	118,135	13.17	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	37,264	17.92	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,224	15,667	150,818	9.63	15
16	Dishwashers					16
17	Maintenance Workers	4,866	4,986	53,557	10.74	17
18	Housekeepers	12,719	12,967	117,508	9.06	18
19	Laundry	4,753	4,906	54,501	11.11	19
20	Administrator	1,584	1,745	65,536	37.56	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,080	2,080	45,365	21.81	23
24	Clerical	1,572	1,615	19,567	12.12	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,080	2,080	63,222	30.40	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Page 20A</u>	5,699	5,978	127,330	21.30	33
34	TOTAL (lines 1 - 33)	132,541	135,913	\$ 2,014,902 *	\$ 14.82	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	Monthly	\$ 607	L1, C3	35
36	Medical Director	Monthly	18,000	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	8,988	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	8	521	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)	8	\$ 28,116		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	975	\$ 29,473	L10, C3	50
51	Licensed Practical Nurses	2,440	67,043	L10, C3	51
52	Certified Nurse Assistants/Aides	83	1,160	L10, C3	52
53	TOTAL (lines 50 - 52)	3,498	\$ 97,676		53

El Paso Health Care Center

0050914

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	1,769	1,817	53,750	29.58
Transportation	1,953	2,075	38,799	18.70
Marketing	1,977	2,086	34,781	16.67
TOTAL	5,699	5,978	127,330	

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	
Trisha Harris	Administrator	0	\$ 34,140	Workers' Compensation Insurance	\$ 32,511	IDPH License Fee	\$ 1,990	
Keegan Collier	Administrator	0	31,396	Unemployment Compensation Insurance	21,931	Advertising: Employee Recruitment	184	
				FICA Taxes	147,981	Health Care Worker Background Check (Indicate # of checks performed <u>26</u>)		
				Employee Health Insurance	1,137	Patient Background Checks	1,193	
				Employee Meals		Miscellaneous Licenses & Permits	652	
				Illinois Municipal Retirement Fund (IMRF)*		Home Office Allocation	5,921	
				Employee Relations	852			
				Home Office Allocation	34,399			
				Employee Retirement	757			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 65,536	TOTAL (agree to Schedule V, line 22, col.8)		\$ 9,940		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 332,500				Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 332,500				Seminar Expense	
C. Professional Services				TOTAL			\$ 4	
Vendor/Payee	Type		Amount				Home Office Allocation	4
Mediacom	Computer Services		1,456				Entertainment Expense	()
Ability Network	Computer Services		1,073				TOTAL (agree to Sch. V, line 24, col. 8)	
								\$ 4
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 2,529					

* Attach copy of IMRF notifications

**See instructions.

El Paso Health Care Center

0050914

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)		2,529

Home Office Allocation

Duane Morris	Legal	3302
Sedgwick CMS	Legal	292
SB2	Legal	815
Miscellaneous	Legal	243
Christoper P. Ryan	Legal	258
Saul Ewing Arnstein & Lehr	Legal	1156
Healthcare Resources International	Legal	173
Winston & Strawn	Legal	2783
Lexis Nexis	Legal	12
Pretzel & Stouffer	Legal	41
Baker Tilly Virchow Krause	Legal	1180
Wells Fargo	Legal	743
CliftonLarsonAllen	Accounting	1689
Ginoli & Co.	Accounting	599
Duane Morris	Accounting	98
Getzler Henrich & Associates	Accounting	1297
Kemper Consulting	Accounting	98
Baker Tilly Virchow Krause	Accounting	683
Ginoli & Co.	Accounting	2622
Wells Fargo	Accounting	2495
Miscellaneous	Computer Services	183
Change Healthcare	Computer Services	6
TR Professional	Computer Services	17
Matrix Care	Computer Services	1897
Ability Network	Computer Services	3004
Stratus Networks	Computer Services	734
Kemper Technology	Computer Services	843
AT&T	Computer Services	10
Ungerboeck Software	Computer Services	607
CIAN	Computer Services	264
Comcast	Computer Services	65
CCH	Computer Services	25
Charter Communications	Computer Services	44
Allscripts	Computer Services	853
ATS	Computer Services	396
Citrix Systems	Computer Services	139
Optimizer	Other Prof Fees	77
Sedgwick CLMS	Other Prof Fees	267
David Budde	Other Prof Fees	76
Sargent Consulting	Other Prof Fees	210
Alix Partners	Other Prof Fees	796
Getzler Henrich & Associates	Other Prof Fees	108
Sargent Consulting	Other Prof Fees	2139

Total (agree to Schedule V, line 19, column 8)	<u><u>35,868</u></u>
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EI Paso Health Care Center

0050914

Period Beginning 1/1/2018

Period End 12/31/2018

Schedule 21B

25. Administrative and Staff Transportation

Gas	\$ 6,714
Auto Repairs	6,350
Travel-Mileage	3,649
Home Office Allocation	6,076
	<u>22,789</u>

Facility Name & ID Number El Paso Health Care Center# 0050914Report Period Beginning: 1/1/2018Ending: 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 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. \$ 13,829 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. \$ 263,463
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. \$ 228
- (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. \$ 30,761
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. \$
- (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