

Facility Name & ID Number Jonesboro Rehabilitation & Health Care Center

0053207 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	19	Skilled (SNF)	19	6,935	1
2		Skilled Pediatric (SNF/PED)			2
3	58	Intermediate (ICF)	58	21,170	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	77	TOTALS	77	28,105	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		1,382	969	2,351	8
9	SNF/PED					9
10	ICF	11,623			11,623	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,623	1,382	969	13,974	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 49.72%

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

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

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

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 19 and days of care provided 861

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

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

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

Facility Name & ID Number Jonesboro Rehabilitation & Health Care Cen # 0053207 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	112,475	9,899	4,653	127,027		127,027	3,394	130,421		1
2	Food Purchase		91,034		91,034		91,034	(1,846)	89,188		2
3	Housekeeping	115,067	17,573		132,640		132,640	54	132,694		3
4	Laundry	64	9,574		9,638		9,638		9,638		4
5	Heat and Other Utilities			73,664	73,664		73,664	173	73,837		5
6	Maintenance	36,062	7,114	18,704	61,880		61,880	1,964	63,844		6
7	Other (specify):* Home Office Ben. Allocation										7
8	TOTAL General Services	263,668	135,194	97,021	495,883		495,883	3,739	499,622		8
	B. Health Care and Programs										
9	Medical Director			7,200	7,200		7,200		7,200		9
10	Nursing and Medical Records	788,251	72,730	(11,134)	849,847		849,847	1,864	851,711		10
10a	Therapy			157,200	157,200		157,200		157,200		10a
11	Activities	41,515	30	367	41,912		41,912	(9,212)	32,700		11
12	Social Services	27,244			27,244		27,244		27,244		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Office Ben. Allocation										15
16	TOTAL Health Care and Programs	857,010	72,760	153,633	1,083,403		1,083,403	(7,348)	1,076,055		16
	C. General Administration										
17	Administrative			193,900	193,900		193,900	(124,182)	69,718		17
18	Directors Fees										18
19	Professional Services			2,978	2,978		2,978	17,197	20,175		19
20	Dues, Fees, Subscriptions & Promotions			823	823		823	2,518	3,341		20
21	Clerical & General Office Expenses	22,735	1,252	7,841	31,828		31,828	35,231	67,059		21
22	Employee Benefits & Payroll Taxes			116,793	116,793		116,793	14,626	131,419		22
23	Inservice Training & Education							85	85		23
24	Travel and Seminar							2	2		24
25	Other Admin. Staff Transportation			5,491	5,491		5,491	2,584	8,075		25
26	Insurance-Prop.Liab.Malpractice			1,841	1,841		1,841	40,435	42,276		26
27	Other (specify):* Home Office Ben. Allocation										27
28	TOTAL General Administration	22,735	1,252	329,667	353,654		353,654	(11,504)	342,150		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,143,413	209,206	580,321	1,932,940		1,932,940	(15,113)	1,917,827		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 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			1,168	1,168		1,168	62,900	64,068			30
31	Amortization of Pre-Op. & Org.							3,022	3,022			31
32	Interest							146,555	146,555			32
33	Real Estate Taxes							39,771	39,771			33
34	Rent-Facility & Grounds			285,916	285,916		285,916	(285,916)				34
35	Rent-Equipment & Vehicles			20,398	20,398		20,398	746	21,144			35
36	Other (specify):*											36
37	TOTAL Ownership			307,482	307,482		307,482	(32,922)	274,560			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		19,317		19,317		19,317		19,317			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			121,177	121,177		121,177		121,177			42
43	Other (specify):* Miscellaneous	4,405	267	23,200	27,872		27,872	(27,872)				43
44	TOTAL Special Cost Centers	4,405	19,584	144,377	168,366		168,366	(27,872)	140,494			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,147,818	228,790	1,032,180	2,408,788		2,408,788	(75,907)	2,332,881			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	(1,878)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	3,020	30		9
10	Interest and Other Investment Income	(894)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(90)	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	(12,443)	43		18
19	Entertainment				19
20	Contributions	(75)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(12,000)	43		24
25	Fund Raising, Advertising and Promotional	(324)	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	(12,658)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (37,342)		\$	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)	(38,565)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (38,565)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (75,907)		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

Jonesboro Rehabilitation & Health Care Center

ID# 0053207

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	Sch. V Line
1	Labs-Part A	\$ 3,779	43	1
2	X-Rays-Part A	(648)	43	2
3	Disallowed Special Events	(1,666)	43	3
4	Offset Miscellaneous Office Supplies Revenue	(21)	21	4
5	Offset Transportation income	(9,212)	11	5
6	Disallowed Chamber of Commerce Dues		20	6
7	Disallowed Marketing Salaries	(4,405)	43	7
8	Offset Miscellaneous Nursing Supplies Revenue	(485)	10	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
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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	(12,658)		49

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	1 Dietary	\$	Petersen Health Care Management, Inc.	100.00%	\$ 3,394	\$ 3,394	1
2	V	2 Food		Petersen Health Care Management, Inc.	100.00%	32	32	2
3	V	3 Housekeeping		Petersen Health Care Management, Inc.	100.00%	54	54	3
4	V	5 Utilities		Petersen Health Care Management, Inc.	100.00%	173	173	4
5	V	6 Maintenance		Petersen Health Care Management, Inc.	100.00%	1,331	1,331	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%	2,349	2,349	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	107,500	Petersen Health Care Management, Inc.	100.00%	69,718	(37,782)	11
12	V	19 Professional Services		Petersen Health Care Management, Inc.	100.00%	10,272	10,272	12
13	V							13
14	Total		\$ 107,500			\$ 87,323	\$ * (20,177)	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%	\$ 2,518	\$	2,518	15
16	V	21 <u>Clerical and General Office</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	34,824		34,824	16
17	V	22 <u>Employee Benefits and Payroll Taxes</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	14,626		14,626	17
18	V	23 <u>Inservice Training & Education</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	85		85	18
19	V	24 <u>Travel and Seminar</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	2		2	19
20	V	25 <u>Other Admin. Staff Transport.</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	2,584		2,584	20
21	V	26 <u>Insurance-Prop./Liab./Malprac.</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	648		648	21
22	V	27 <u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	8,236		8,236	22
23	V	30 <u>Depreciation</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	75		75	23
24	V	32 <u>Interest</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	2,166		2,166	24
25	V	33 <u>Real Estate Taxes</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	256		256	25
26	V	35 <u>Rent-Equipment & Vehicles</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	746		746	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		\$			\$ 66,766	\$ *	66,766	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 Properties, LLC	100.00%	\$ 0	\$	15
16	V	2 Food		Petersen Health Properties, LLC	100.00%	0		16
17	V	3 Housekeeping		Petersen Health Properties, LLC	100.00%	0		17
18	V	4 Laundry		Petersen Health Properties, LLC	100.00%	0		18
19	V	5 Utilities		Petersen Health Properties, LLC	100.00%	0		19
20	V	6 Maintenance		Petersen Health Properties, LLC	100.00%	0		20
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Properties, LLC	100.00%	0		21
22	V	10 Nursing and Medical Records		Petersen Health Properties, LLC	100.00%	0		22
23	V	15 Mgmt. Allocation of Benefits		Petersen Health Properties, LLC	100.00%	0		23
24	V	17 Administrative	86,400	Petersen Health Properties, LLC	100.00%	0	(86,400)	24
25	V	19 Professional Services		Petersen Health Properties, LLC	100.00%	605	605	25
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Properties, LLC	100.00%	0		26
27	V	21 Clerical and General Office		Petersen Health Properties, LLC	100.00%	0		27
28	V	22 Employee Benefits & Payroll		Petersen Health Properties, LLC	100.00%	0		28
29	V	23 Inservice Training & Education		Petersen Health Properties, LLC	100.00%	0		29
30	V	24 Travel and Seminar		Petersen Health Properties, LLC	100.00%	0		30
31	V	25 Other Admin. Staff Transport.		Petersen Health Properties, LLC	100.00%	0		31
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Properties, LLC	100.00%	0		32
33	V	30 Depreciation		Petersen Health Properties, LLC	100.00%	0		33
34	V	31 Amortization		Petersen Health Properties, LLC	100.00%	0		34
35	V	32 Interest		Petersen Health Properties, LLC	100.00%	32,528	32,528	35
36	V	33 Real Estate Taxes		Petersen Health Properties, LLC	100.00%	0		36
37	V	34 Rent-Facility and Grounds		Petersen Health Properties, LLC	100.00%	0		37
38	V	35 Rent-Equipment & Vehicles		Petersen Health Properties, LLC	100.00%	0		38
39	Total		\$ 86,400			\$ 33,133	\$ * (53,267)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	6 Maintenance	\$	Jonesboro Land	100.00%	\$ 633	\$	633	15
16	V	19 Professional Fees		Jonesboro Land	100.00%	6,320		6,320	16
17	V	21 Equipment		Jonesboro Land	100.00%	428		428	17
18	V	26 Insurance-Liability		Jonesboro Land	100.00%	17,408		17,408	18
19	V	26 Insurance-Property		Jonesboro Land	100.00%	4,338		4,338	19
20	V	26 Insurance-MIP		Jonesboro Land	100.00%	18,041		18,041	20
21	V	30 Depreciation		Jonesboro Land	100.00%	51,644		51,644	21
22	V	31 Amortization of Pre-Op. & Org.		Jonesboro Land	100.00%	2,947		2,947	22
23	V	32 Interest	954	Jonesboro Land	100.00%	113,709		112,755	23
24	V	33 Real Estate Taxes		Jonesboro Land	100.00%	39,515		39,515	24
25	V	34 Rent-Facility and Grounds	285,916	Jonesboro Land	100.00%			(285,916)	25
26	V								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		\$ 286,870			\$ 254,983	\$ *	(31,887)	39

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

Facility Name & ID Number

Jonesboro Rehabilitation & Health Care Center

0053207

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

Jonesboro Rehabilitation & Health Care Center

0053207

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 Jonesboro Rehabilitation & Health Care Cen # 0053207 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 Jonesboro Rehabilitation & Health Care Center # 0053207 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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,411,762	75	\$ 342,871	\$ 393,211	13,974	\$ 3,394	1
2	2	Food	Resident Days	1,411,762	75	3,216	0	13,974	32	2
3	3	Housekeeping	Resident Days	1,411,762	75	5,441	2,652	13,974	54	3
4	5	Utilities	Resident Days	1,411,762	75	17,524	0	13,974	173	4
5	6	Maintenance	Resident Days	1,411,762	75	134,460	148,272	13,974	1,331	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,411,762	75	0	0	13,974	0	6
7	9	Medical Director	Resident Days	1,411,762	75	0	0	13,974	0	7
8	10	Nursing and Medical Records	Resident Days	1,411,762	75	237,275	1,454,984	13,974	2,349	8
9	10A	Therapy	Resident Days	1,411,762	75	0	0	13,974	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,411,762	75	0	0	13,974	0	10
11	17	Administrative	Resident Days	1,411,762	75	4,940,583	5,658,897	13,974	69,718	11
12	19	Professional Services	Resident Days	1,411,762	75	1,037,806	0	13,974	10,272	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,411,762	75	254,355	0	13,974	2,518	13
14	21	Clerical and General Office	Resident Days	1,411,762	75	3,518,216	3,764,024	13,974	34,824	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,411,762	75	1,477,639	0	13,974	14,626	15
16	23	Inservice Training & Education	Resident Days	1,411,762	75	8,601	0	13,974	85	16
17	24	Travel and Seminar	Resident Days	1,411,762	75	174	0	13,974	2	17
18	25	Other Admin. Staff Transport.	Resident Days	1,411,762	75	261,018	0	13,974	2,584	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,411,762	75	65,437	0	13,974	648	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,411,762	75	832,087	0	13,974	8,236	20
21	30	Depreciation	Resident Days	1,411,762	75	7,528	0	13,974	75	21
22	32	Interest	Resident Days	1,411,762	75	218,814	0	13,974	2,166	22
23	33	Real Estate Taxes	Resident Days	1,411,762	75	25,901	0	13,974	256	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,411,762	75	75,380	0	13,974	746	24
25	TOTALS					\$ 13,464,326	\$ 11,422,040		\$ 154,089	25

Facility Name & ID Number Jonesboro Rehabilitation & Health Care Center # 0053207 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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	57,169	3	\$	13,974	\$	1
2	2	Food	Resident Days	57,169	3		13,974		2
3	3	Housekeeping	Resident Days	57,169	3		13,974		3
4	4	Laundry	Resident Days	57,169	3		13,974		4
5	5	Utilities	Resident Days	57,169	3		13,974		5
6	6	Maintenance	Resident Days	57,169	3		13,974		6
7	7	Mgmt. Allocation of Benefits	Resident Days	57,169	3		13,974		7
8	10	Nursing and Medical Records	Resident Days	57,169	3		13,974		8
9	15	Mgmt. Allocation of Benefits	Resident Days	57,169	3		13,974		9
10	17	Administrative	Resident Days	57,169	3		13,974		10
11	19	Professional Services	Resident Days	57,169	3	2,475	13,974	605	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	57,169	3		13,974		12
13	21	Clerical and General Office	Resident Days	57,169	3		13,974		13
14	22	Employee Benefits & Payroll	Resident Days	57,169	3		13,974		14
15	23	Inservice Training & Education	Resident Days	57,169	3		13,974		15
16	24	Travel and Seminar	Resident Days	57,169	3		13,974		16
17	25	Other Admin. Staff Transport.	Resident Days	57,169	3		13,974		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	57,169	3		13,974		18
19	30	Depreciation	Resident Days	57,169	3		13,974		19
20	31	Amortization	Resident Days	57,169	3		13,974		20
21	32	Interest	Resident Days	57,169	3	133,077	13,974	32,528	21
22	33	Real Estate Taxes	Resident Days	57,169	3		13,974		22
23	34	Rent-Facility and Grounds	Resident Days	57,169	3		13,974		23
24	35	Rent-Equipment & Vehicles	Resident Days	57,169	3		13,974		24
25	TOTALS					\$ 135,552	\$	\$ 33,133	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					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	Busey Bank		X	Mortgage	Varies	1/1/2015	2,972,244	\$ 2,755,753	12/31/2044	Varies	\$ 113,709	1				
2												2				
3												3				
4												4				
5												5				
Working Capital																
6												6				
7												7				
8												8				
9	TOTAL Facility Related						\$ 2,972,244	\$ 2,755,753			\$ 113,709	9				
B. Non-Facility Related*																
10								Interest Income Offset			(1,848)	10				
11								Home Office Allocation-PHP			32,528	11				
12								Home Office Allocation-PHCM			2,166	12				
13												13				
14	TOTAL Non-Facility Related						\$	\$			\$ 32,846	14				
15	TOTALS (line 9+line14)						\$ 2,972,244	\$ 2,755,753			\$ 146,555	15				

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 18,041 Line # 26

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

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

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Jonesboro Rehabilitation & Health Care Center COUNTY Union

FACILITY IDPH LICENSE NUMBER 0053207

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>05-31-04-116</u>	<u>Long-Term Care Facility</u>	\$ <u>38,698.94</u>	\$ <u>38,698.94</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>38,698.94</u></u>	\$ <u><u>38,698.94</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: 16,690 B. General Construction Type: Exterior Masonry Frame Wood Number of Stories 1

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

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

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

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

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

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

N/A

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

1. Total Amount Incurred: 88,411 2. Number of Years Over Which it is Being Amortized: 1
3. Current Period Amortization: 3,022 4. Dates Incurred: 2013-2015

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>131,116</u>	<u>2005</u>	<u>\$ 67,500</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	131,116		\$ 67,500	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	77	2005	1972	\$ 1,048,000	\$	25	\$ 41,920	\$ 41,920	\$ 556,312	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Original Land		2005	15,000		5			15,000	9
10	Carpet		2006	10,359		5			10,359	10
11	Sidewalks		2006	7,886		15	526	526	6,049	11
12	Sidewalks		2007	1,473		15	98	98	1,029	12
13	Carpet		2007	5,040		5			5,040	13
14	Roof Work		2007	3,800		15	253	253	2,657	14
15	Landscaping		2008	3,000		39	76	76	722	15
16	Fire Door repair		2008	2,639		20	132	132	1,254	16
17	Sprinkler System		2008	42,900		39	1,100	1,100	10,450	17
18	Furnish and install master meter		2008	35,000		25	1,400	1,400	13,300	18
19	Roof Repair		2010	15,284		7	2,184	2,184	16,380	19
20	Generator		2011	16,960		15	1,130	1,130	7,345	20
21	Fire Alarm Replacement		2016	4,109		7	588	588	1,470	21
22	Parking Lot Resurfacing		2017	32,869		15	2,192	2,192	3,288	22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30	Land Improvements Booked				1,701			(1,701)		30
31	Building Booked				41,920			(41,920)		31
32	Building Improvement Booked				7,639			(7,639)		32
33										33
34	2018-Home Office Allocation-Building Improvements			6,573			158	158		34
35	2018-Home Office Allocation-Land Improvements			659			42	42		35
36										36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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	\$ 38,789	\$ 1,453	\$ 3,936	\$ 2,483	5-10 yrs.	\$ 28,538	71
72	Current Year Purchases	4,163	99	297	198	7 yrs.	297	72
73	Fully Depreciated Assets	243,572					243,572	73
74	Home Office Allocation			8,036	8,036			74
75	TOTALS	\$ 286,524	\$ 1,552	\$ 12,269	\$ 10,717		\$ 272,407	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)	\$ 1,605,575	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 52,812	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 64,068	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 11,256	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 923,062	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.

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: \$ 21,144 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.

**Jonesboro Rehabilitation & Health Care Center
0053207**

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	\$ 16,176
Dishwasher	701
Copier	3,521
Home Office Allocation	746
	<u>21,144</u>

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	2,695	\$ 40,420	\$	2,695	\$ 40,420	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,542	23,134		1,542	23,134	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		6,243	93,646		6,243	93,646	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescripts				19,317		19,317	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____									13
14	TOTAL			\$	10,480	\$ 157,200	\$ 19,317	10,480	\$ 176,517	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 Jonesboro Rehabilitation & Health Care Center

0053207

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	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (1,352,650)	\$ (1,352,650)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 194,100)	2,051,488	2,051,488	3
4	Supply Inventory (priced at Cost)	9,944	9,944	4
5	Short-Term Investments			5
6	Prepaid Insurance	34,585	45,320	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	14,914	37,959	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 758,281	\$ 792,061	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		67,500	13
14	Buildings, at Historical Cost		1,054,573	14
15	Leasehold Improvements, at Historical Cost	4,109	196,978	15
16	Equipment, at Historical Cost	6,624	286,524	16
17	Accumulated Depreciation (book methods)	(5,550)	(923,062)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		81,043	19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		283,671	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Intercompany Loans</u>	5,692	16,017	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 10,875	\$ 1,063,244	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 769,156	\$ 1,855,305	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 367,324	\$ 371,487	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	57,930	57,930	30
31	Accrued Taxes Payable (excluding real estate taxes)	913	913	31
32	Accrued Real Estate Taxes(Sch.IX-B)		39,864	32
33	Accrued Interest Payable		9,393	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	316,404	316,404	36
37	<u>Accrued Management Fees</u>	398,634	398,634	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,141,205	\$ 1,194,625	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,755,753	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Intercompany Loans</u>	206,481	206,481	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 206,481	\$ 2,962,234	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,347,686	\$ 4,156,859	46
47	TOTAL EQUITY(page 18, line 24)	\$ (578,530)	\$ (2,301,554)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 769,156	\$ 1,855,305	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (297,277)	1
2	Restatements (describe):		2
3	Adjustments Made After Cost Reports Were Filed	(10,000)	3
4	Rounding	4	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (307,273)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(271,257)	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)	\$ (271,257)	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)	\$ (578,530)	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	\$ 1,904,456	1
2	Discounts and Allowances for all Levels	(117,812)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,786,644	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	287,393	6
7	Oxygen	46	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 287,439	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,878	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	38,573	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	3,947	20
21	Other Medical Services	8,392	21
22	Laundry	46	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 52,836	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	894	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 894	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Transportation Revenue</u>	9,212	28
28a	<u>Miscellaneous Revenue</u>	506	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 9,718	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,137,531	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	495,883	31
32	Health Care	1,083,403	32
33	General Administration	353,654	33
B. Capital Expense			
34	Ownership	307,482	34
C. Ancillary Expense			
35	Special Cost Centers	47,189	35
36	Provider Participation Fee	121,177	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,408,788	40
41	Income before Income Taxes (line 30 minus line 40)**	(271,257)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (271,257)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,422,516	44
45	Private Pay - Net Inpatient Revenue	167,233	45
46	Medicare - Net Inpatient Revenue	169,982	46
47	Other-(specify) <u>Insurance Net Inpatient Revenue</u>	26,913	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 1,786,644	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 Jonesboro Rehabilitation & Health Care Center

0053207

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	1,380	1,380	\$ 49,933	\$ 36.18	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,085	5,161	133,240	25.82	3
4	Licensed Practical Nurses	8,337	8,517	208,726	24.51	4
5	CNAs & Orderlies	24,438	24,959	295,892	11.86	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	566	566	8,497	15.01	8
9	Activity Director	1,499	1,499	22,069	14.72	9
10	Activity Assistants					10
11	Social Service Workers	1,954	2,112	27,244	12.90	11
12	Dietician					12
13	Food Service Supervisor	1,984	1,984	33,415	16.84	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,656	8,092	79,060	9.77	15
16	Dishwashers					16
17	Maintenance Workers	1,959	2,068	36,062	17.44	17
18	Housekeepers	11,626	11,895	115,067	9.67	18
19	Laundry	7	7	64	9.14	19
20	Administrator	1,928	1,928	69,718	36.16	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,544	1,544	22,735	14.72	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	4,514	4,667	115,814	24.82	33
34	TOTAL (lines 1 - 33)	74,477	76,379	\$ 1,217,536 *	\$ 15.94	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	\$ 4,653	L1, C3	35
36	Medical Director	Monthly	7,200	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,812	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	4	231	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)	4	\$ 15,896		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	28	\$ 1,008	L10, C3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	43	1,063	L10, C3	52
53	TOTAL (lines 50 - 52)	71	\$ 2,071		53

Jonesboro Rehabilitation & Health Care Center

0053207

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	2,715	2,715	91,963	33.87
Transportation	1,436	1,589	19,446	12.24
Marketing	363	363	4,405	12.13
TOTAL	4,514	4,667	115,814	

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			
Tracey Cross	Administrator	0	\$ 63,635	Workers' Compensation Insurance	\$ 20,353	IDPH License Fee	\$			
Candy Tucker	Administrator	0	6,083	Unemployment Compensation Insurance	6,867	Advertising: Employee Recruitment				
				FICA Taxes	87,648	Health Care Worker Background Check				
				Employee Health Insurance	584	(Indicate # of checks performed <u>7</u>)	210			
				Employee Meals	0	Patient Background Checks				
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	613			
				Employee Relations	1,069	Home Office Allocation	2,518			
				Home Office Allocation	14,626					
				Employee Retirement	272					
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 69,718	TOTAL (agree to Schedule V, line 22, col.8)			\$ 131,419	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 3,341
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			\$ 193,900				Out-of-State Travel	\$		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 193,900	N/A			In-State Travel			
C. Professional Services				TOTAL			\$	Seminar Expense		
Vendor/Payee	Type		Amount				Home Office Allocation	2		
Ability Network	Computer Services		\$ 1,073				Entertainment Expense	()		
Frontier	Computer Services		1,846				TOTAL (agree to Sch. V, line 24, col. 8)		\$ 2	
Busey Bank	Legal Fees		59							
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 2,978							

* Attach copy of IMRF notifications

**See instructions.

Jonesboro Rehabilitation & Health Care Center

0053207

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)		2,978

Home Office Allocation

Duane Morris	Legal	1404
Sedgwick CMS	Legal	124
SB2	Legal	347
Miscellaneous	Legal	103
Christopher P. Ryan	Legal	110
Saul Ewing Arnstein & Lehr	Legal	492
Healthcare Resources International	Legal	74
Winston & Strawn	Legal	1183
Lexis Nexis	Legal	5
Pretzel & Stouffer	Legal	17
CIBC	Legal	250
CliftonLarsonAllen	Accounting	718
Ginoli & Co.	Accounting	860
Duane Morris	Accounting	42
Getzler Henrich & Associates	Accounting	552
Kemper Consulting	Accounting	42
Baker Tilly Virchow Krause	Accounting	291
CIBC	Accounting	6070
Miscellaneous	Computer Services	74
Change Healthcare	Computer Services	3
TR Professional	Computer Services	7
Matrix Care	Computer Services	807
Ability Network	Computer Services	1277
Stratus Networks	Computer Services	312
Kemper Technology	Computer Services	358
AT&T	Computer Services	4
Ungerboeck Software	Computer Services	258
CIAN	Computer Services	112
Comcast	Computer Services	28
CCH	Computer Services	11
Charter Communications	Computer Services	19
Allscripts	Computer Services	363
ATS	Computer Services	169
Citrix Systems	Computer Services	59
Optimizer	Other Prof Fees	33
Sedgwick CLMS	Other Prof Fees	113
David Budde	Other Prof Fees	32
Sargent Consulting	Other Prof Fees	89
Alix Partners	Other Prof Fees	339
Getzler Henrich & Associates	Other Prof Fees	<u>46</u>

Total (agree to Schedule V, line 19, column 8)	<u><u>20,175</u></u>
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**Jonesboro Rehabilitation & Health Care Center
0053207**

Period Beginning 1/1/2018
Period End 12/31/2018

Schedule 14A

25. Administrative and Staff Transportation

Gas	\$	2,659
Auto Repairs		863
Mileage-Travel		1,969
Home Office Allocation		<u>2,584</u>
		<u><u>8,075</u></u>

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. \$ 19,114 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. \$ 121,177
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,878
- (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. \$ 9,212
 - 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

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-75,907	equal to	-75,907	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	146,555	equal to	146,555	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	39,771	equal to	39,771	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening	3,022	equal to	3,022	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	64,068	equal to	64,068	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	21,144	equal to	21,144	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to	0	0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	157,200	equal to	157,200	0	O.K.	Pg16 Z12+Z14..	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv.- Supplies	19,317	equal to	19,317	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	495,883	equal to	495,883	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	1,083,403	equal to	1,083,403	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	353,654	equal to	353,654	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	307,482	equal to	307,482	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	47,189	equal to	47,189	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+1	N/A	38to41+43	4
Income Stat. Prov. Partic.	121,177	equal to	121,177	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	788,251	equal to	788,251	0	O.K.	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to	0	0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	41,515	equal to	41,515	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	27,244	equal to	27,244	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	112,475	equal to	112,475	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	36,062	equal to	36,062	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	115,067	equal to	115,067	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	64	equal to	64	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	69,718	equal to	69,718	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	22,735	equal to	22,735	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to	0	0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	1,217,536	equal to	1,147,818	69,718	FAILED	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	4,653	< or = to	4,653	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	7,200	< or = to	7,200	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	6,114	< or = to	-11,134	17,248	FAILED	Pg20 X14..X16+	B. & C.	7to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to	367	-367	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	0	< or = to	0	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	69,718	equal to	69,718	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	193,900	equal to	193,900	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	2,978	equal to	2,978	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	131,419	equal to	131,419	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched. of dues..	3,341	equal to	3,341	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	2	equal to	2	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	121,177	equal to	121,177	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to	0	0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	861	equal to	969	-108	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. cost	-38,565	equal to	-38,565	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4	B.	14	8
Total loan balance	2,755,753	equal to	2,755,753	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27.	N/A	29+39-41	2
Real estate tax accrual	39,864	equal to	39,864	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	67,500	equal to	67,500	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	1,251,551	equal to	1,251,551	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	286,524	equal to	286,524	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	923,062	equal to	923,062	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	-578,530	equal to	-578,530	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	-271,257	equal to	-271,257	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cr	0	equal to	0	0	O.K.	Pg22 F31-J31..	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	769,156	equal to	769,156	0	O.K.	Pg17:H41	N/A	25	1	Pg17 S41	N/A	48	1

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Adjusted Total
1. Dietary	112,475	9,899	4,653	127,027	0	127,027	3,394	130,421
2. Food Purchase	0	91,034	0	91,034	0	91,034	-1,846	89,188
3. Housekeeping	115,067	17,573	0	132,640	0	132,640	54	132,694
4. Laundry	64	9,574	0	9,638	0	9,638	0	9,638
5. Heat and Other Utilities	0	0	73,664	73,664	0	73,664	173	73,837
6. Maintenance	36,062	7,114	18,704	61,880	0	61,880	1,964	63,844
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	263,668	135,194	97,021	495,883	0	495,883	3,739	499,622
9. Medical Director	0	0	7,200	7,200	0	7,200	0	7,200
10. Nursing & Medical Records	788,251	72,730	-11,134	849,847	0	849,847	1,864	851,711
10a. Therapy	0	0	157,200	157,200	0	157,200	0	157,200
11. Activities	41,515	30	367	41,912	0	41,912	-9,212	32,700
12. Social Services	27,244	0	0	27,244	0	27,244	0	27,244
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	857,010	72,760	153,633	1,083,403	0	1,083,403	-7,348	#####
17. Administrative	0	0	193,900	193,900	0	193,900	-124,182	69,718
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	2,978	2,978	0	2,978	17,197	20,175
20. Fees, Subscriptions & Promotion	0	0	823	823	0	823	2,518	3,341
21. Clerical & General Office	22,735	1,252	7,841	31,828	0	31,828	35,231	67,059
22. Employee Benefits & Payroll	0	0	116,793	116,793	0	116,793	14,626	131,419
23. Inservice Training & Education	0	0	0	0	0	0	85	85
24. Travel and Seminar	0	0	0	0	0	0	2	2
25. Other Admin. Staff Trans	0	0	5,491	5,491	0	5,491	2,584	8,075
26. Insurance-Prop.Liab.Malpractice	0	0	1,841	1,841	0	1,841	40,435	42,276
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	22,735	1,252	329,667	353,654	0	353,654	-11,504	342,150
29. Total General Administrative	1,143,413	209,206	580,321	1,932,940	0	1,932,940	-15,113	#####
30. Depreciation	0	0	1,168	1,168	0	1,168	62,900	64,068
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	3,022	3,022
32. Interest	0	0	0	0	0	0	146,555	146,555
33. Real Estate	0	0	0	0	0	0	39,771	39,771
34. Rent - Facility & Grounds	0	0	285,916	285,916	0	285,916	-285,916	0
35. Rent - Equipment & Vehicles	0	0	20,398	20,398	0	20,398	746	21,144
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	307,482	307,482	0	307,482	-32,922	274,560
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	19,317	0	19,317	0	19,317	0	19,317
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	121,177	121,177	0	121,177	0	121,177
43. Other (specify):*	4,405	267	23,200	27,872	0	27,872	-27,872	0
44. Total Special Cost Ce	4,405	19,584	144,377	168,366	0	168,366	-27,872	140,494
45. Grand Total	1,147,818	228,790	1,032,180	2,408,788	0	2,408,788	-75,907	#####

		After Operating Consolidation
General Service Cost Center		
1. Cash on hand and in banks	#####	-1,352,650
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	2,051,488	2,051,488
4. Supply Inventory	9,944	9,944
5. Short-Term Investments	0	0
6. Prepaid Insurance	34,585	45,320
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	14,914	37,959
9. Other (specify):	0	0
10. Total current assets	758,281	792,061
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	0	67,500
14. Buildings, at Historical Cost	0	1,054,573
15. Leasehold Improvements, Historical Cost	4,109	196,978
16. Equipment, at Historical Cost	6,624	286,524
17. Accumulated Depreciation (book methods)	-5,550	-923,062
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	81,043
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	283,671
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	5,692	16,017
24. Total Long-Term Assets	10,875	1,063,244
25. Total Assets	769,156	1,855,305
CURRENT LIABILITIES		
26. Accounts Payable	367,324	371,487
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	57,930	57,930
31. Accrued Taxes Payable	913	913
32. Accrued Real Estate Taxes	0	39,864
33. Accrued Interest Payable	0	9,393
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	316,404	316,404
37. Other Current Liabilities (specify):	398,634	398,634
38. Total Current Liabilities	1,141,205	1,194,625
LONG TERM LIABILITES		
39. Long-Term Notes Payable	0	0
40. Mortgage Payable	0	2,755,753
41. Bonds Payable	0	0
42. Deferred Compensation	0	0
43. Other Long-Term Liabilities (specify):	206,481	206,481
44. Other Long-Term Liabilities (specify):	0	0
45. Total Long-Term Liabilities	206,481	2,962,234
46. Total Liabilities	1,347,686	4,156,859
47. Total Equity	-578,530	-2,301,554
48. Total Liabilities and Equity	769,156	1,855,305

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	1,904,456
2. Discounts and Allowances for all Levels	-117,812
Subtotal - Inpatient Care	1,786,644
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	287,393
7. Oxygen	46
Subtotal - Ancillary Revenue	287,439
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	1,878
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	38,573
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiology and X-Ray	3,947
21. Other Medical Services	8,392
22. Laundry	46
Subtotal - Other Operating Revenue	52,836
24. Contributions	0
25. Interest and Other Investments Income	894
Subtotal - Non-Operating Revenue	894
27. Other Revenue (specify):	9,212
28. Other Revenue (specify):	506
Subtotal - Other Revenue	9,718
30. Total Revenue	2,137,531
31. General Services	509,925
32. Health Care	1,118,560
33. General Administration	355,380
34. Ownership	341,658
35. Special Cost Centers	147,056
35. Provider Participation Fee	129,858
37. Other	0
40. Total Expenses	2,602,437
41. Income Before Income Taxes	-464,906
42. Income Taxes	0
43. Net Income or Loss for the Year	-464,906