		FOR BHF USE					

LL1

IMPORTANT NOTICE

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

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

I. IDPH License ID Number: 0053132

Facility Name: Kewanee Care Home

Address: 144 Junior Ave. (Number) Kewanee (City) 61443 (Zip Code)

County: Henry

Telephone Number: (309) 853-4429 Fax # (309) 853-4400

HFS ID Number:

Date of Initial License for Current Owners: 06/01/76

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2018 to 12/31/2018 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider	(Signed) ____ (Date)
	(Type or Print Name) Mark B. Petersen
	(Title) Chief Executive Officer
Paid Preparer	(Signed) ____ (Date)
	(Print Name and Title)
	(Firm Name & Address)
	(Telephone) ( ) Fax # ( )

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

Facility Name & ID Number: Kewanee Care Home # 0053132 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	27	Skilled (SNF)	27	9,855	1
2		Skilled Pediatric (SNF/PED)			2
3	57	Intermediate (ICF)	57	20,805	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	84	TOTALS	84	30,660	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF		4,649	3,311	7,960	8
9	SNF/PED					9
10	ICF	16,517			16,517	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,517	4,649	3,311	24,477	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.83%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 6/1/1976

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 27 and days of care provided 2,977

Medicare Intermediary: National Government Services

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number: Kewanee Care Home # 0053132 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	152,835	20,268		173,103		173,103	5,945	179,048			1
2	Food Purchase		148,002		148,002		148,002	(6,419)	141,583			2
3	Housekeeping	101,399	21,833		123,232		123,232	94	123,326			3
4	Laundry	50,831	11,665		62,496		62,496		62,496			4
5	Heat and Other Utilities			47,163	47,163		47,163	304	47,467			5
6	Maintenance	34,650	4,802	31,331	70,783		70,783	5,169	75,952			6
7	Other (specify):* Home Office Ben. Allocation											7
8	TOTAL General Services	339,715	206,570	78,494	624,779		624,779	5,093	629,872			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,114,209	138,046	31,540	1,283,795		1,283,795	3,962	1,287,757			10
10a	Therapy			484,793	484,793		484,793		484,793			10a
11	Activities	55,004	131	161	55,296		55,296	(17,027)	38,269			11
12	Social Services	31,292			31,292		31,292		31,292			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Office Ben. Allocation											15
16	TOTAL Health Care and Programs	1,200,505	138,177	528,494	1,867,176		1,867,176	(13,065)	1,854,111			16
	C. General Administration											
17	Administrative			333,500	333,500		333,500	(255,423)	78,077			17
18	Directors Fees											18
19	Professional Services			3,361	3,361		3,361	63,837	67,198			19
20	Dues, Fees, Subscriptions & Promotions			7,009	7,009		7,009	4,135	11,144			20
21	Clerical & General Office Expenses	32,572	3,297	11,250	47,119		47,119	69,424	116,543			21
22	Employee Benefits & Payroll Taxes			166,471	166,471		166,471	25,619	192,090			22
23	Inservice Training & Education							149	149			23
24	Travel and Seminar							3	3			24
25	Other Admin. Staff Transportation			21,995	21,995		21,995	4,526	26,521			25
26	Insurance-Prop.Liab.Malpractice			20,560	20,560		20,560	29,884	50,444			26
27	Other (specify):* Home Office Ben. Allocation											27
28	TOTAL General Administration	32,572	3,297	564,146	600,015		600,015	(57,846)	542,169			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,572,792	348,044	1,171,134	3,091,970		3,091,970	(65,818)	3,026,152			29

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

Facility Name & ID Number Kewanee Care Home #0053132 **Report Period Beginning:** 1/1/2018 **Ending:** 12/31/2018

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	D. Ownership	Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
30	Depreciation			1,415	1,415		1,415	80,200	81,615			30
31	Amortization of Pre-Op. & Org.							9,276	9,276			31
32	Interest							214,695	214,695			32
33	Real Estate Taxes							61,644	61,644			33
34	Rent-Facility & Grounds			382,648	382,648		382,648	(382,648)				34
35	Rent-Equipment & Vehicles			40,469	40,469		40,469	1,307	41,776			35
36	Other (specify):*											36
37	**TOTAL Ownership**			424,532	424,532		424,532	(15,526)	409,006			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		79,074		79,074		79,074		79,074			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			174,160	174,160		174,160		174,160			42
43	Other (specify):* **Miscellaneous**	28,595	1,769	36,498	66,862		66,862	(66,862)				43
44	**TOTAL Special Cost Centers**	28,595	80,843	210,658	320,096		320,096	(66,862)	253,234			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,601,387	428,887	1,806,324	3,836,598		3,836,598	(148,206)	3,688,392			45

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

Facility Name & ID Number Kewanee Care Home # 0053132 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(5,889)	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	(10,064)	30		9
10	Interest and Other Investment Income	(2,597)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(736)	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	(32,063)	43		18
19	Entertainment				19
20	Contributions	(157)	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		43		24
25	Fund Raising, Advertising and Promotional	(20,052)	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	(31,919)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (103,477)		$	30

BHF USE ONLY

48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(108,716)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (108,716)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (212,193)		37

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

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

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

Kewanee Care Home

ID# 0053132

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs-Part A	$ (8,183)	43	1
2	X-Rays-Part A	(5,671)	43	2
3	Offset of Transportation Income	(17,027)	11	3
4	Offset Chamber of Commerce Dues	(275)	20	4
5	Offset of Office Supplies Income	(25)	21	5
6	Offset of Nursing Supplies Income	(152)	21	6
7	Offset of Meals on Wheels Income	(586)	2	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
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(31,919)		49

Facility Name & ID Number Kewanee Care Home # 0053132 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	$	Petersen Health Care Management, Inc.	100.00%	$ 5,945	$ 5,945	1
2	V	2	Food		Petersen Health Care Management, Inc.	100.00%	56	56	2
3	V	3	Housekeeping		Petersen Health Care Management, Inc.	100.00%	94	94	3
4	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	304	304	4
5	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	2,331	2,331	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%	4,114	4,114	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	248,300	Petersen Health Care Management, Inc.	100.00%	78,077	(170,223)	11
12	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	17,993	17,993	12
13	V								13
14	Total			$ 248,300			$ 108,914	$ * (139,386)	14

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

Facility Name & ID Number Kewanee Care Home # 0053132 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

VII. RELATED PARTIES (continued)

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

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

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	20	Dues, Fees, Subs & Promotions	$	Petersen Health Care Management, Inc.	100.00%	$ 4,410	$ 4,410	15
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	60,999	60,999	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	25,619	25,619	17
18	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	149	149	18
19	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	3	3	19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	4,526	4,526	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	1,135	1,135	21
22	V	27	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	14,427	14,427	22
23	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	131	131	23
24	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	3,794	3,794	24
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	449	449	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	1,307	1,307	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			$			$ 116,949	$ * 116,949	39

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

Facility Name & ID Number Kewanee Care Home # 0053132 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

VII. RELATED PARTIES (continued)

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

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

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Petersen Health Junction, LLC	100.00%	$ 0	$	15
16	V	2	Food		Petersen Health Junction, LLC	100.00%	0		16
17	V	3	Housekeeping		Petersen Health Junction, LLC	100.00%	0		17
18	V	4	Laundry		Petersen Health Junction, LLC	100.00%	0		18
19	V	5	Utilities		Petersen Health Junction, LLC	100.00%	0		19
20	V	6	Maintenance		Petersen Health Junction, LLC	100.00%	0		20
21	V	7	Mgmt. Allocation of Benefits		Petersen Health Junction, LLC	100.00%	0		21
22	V	10	Nursing and Medical Records		Petersen Health Junction, LLC	100.00%	0		22
23	V	15	Mgmt. Allocation of Benefits		Petersen Health Junction, LLC	100.00%	0		23
24	V	17	Administrative		Petersen Health Junction, LLC	100.00%	0		24
25	V	19	Professional Services		Petersen Health Junction, LLC	100.00%	1,025	1,025	25
26	V	20	Dues, Fees, Subs & Promotions		Petersen Health Junction, LLC	100.00%	0		26
27	V	21	Clerical and General Office		Petersen Health Junction, LLC	100.00%	0		27
28	V	22	Employee Benefits & Payroll		Petersen Health Junction, LLC	100.00%	0		28
29	V	23	Inservice Training & Education		Petersen Health Junction, LLC	100.00%	0		29
30	V	24	Travel and Seminar		Petersen Health Junction, LLC	100.00%	0		30
31	V	25	Other Admin. Staff Transport.		Petersen Health Junction, LLC	100.00%	0		31
32	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Junction, LLC	100.00%	0		32
33	V	30	Depreciation		Petersen Health Junction, LLC	100.00%	0		33
34	V	31	Amortization	85,200	Petersen Health Junction, LLC	100.00%	0	(85,200)	34
35	V	32	Interest		Petersen Health Junction, LLC	100.00%	55,090	55,090	35
36	V	33	Real Estate Taxes		Petersen Health Junction, LLC	100.00%	0		36
37	V	34	Rent-Facility and Grounds		Petersen Health Junction, LLC	100.00%	0		37
38	V	35	Rent-Equipment & Vehicles		Petersen Health Junction, LLC	100.00%	0		38
39	Total			$ 85,200			$ 56,115	$ * (29,085)	39

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

Facility Name & ID Number Kewanee Care Home # 0053132 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

VII. RELATED PARTIES (continued)

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

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

	1	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	$	Kewanee Land	100.00%	$ 2,838	$ 2,838	15
16	V	19	Professional Fees		Kewanee Land	100.00%	5,180	5,180	16
17	V	21	Equipment	$	Kewanee Land	100.00%	8,450	8,450	17
18	V	26	Property Insurance		Kewanee Land	100.00%	5,982	5,982	18
19	V	26	Mortgage Insurance		Kewanee Land	100.00%	22,767	22,767	19
20	V	30	Depreciation		Kewanee Land	100.00%	75,837	75,837	20
21	V	31	Amortization		Kewanee Land	100.00%	9,145	9,145	21
22	V	32	Interest	802	Kewanee Land	100.00%	134,862	134,060	22
23	V	33	Real Estate Taxes		Kewanee Land	100.00%	61,195	61,195	23
24	V	34	Rent-Facility & Grounds	382,648	Kewanee Land	100.00%		(382,648)	24
25	V								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			$ 383,450			$ 326,256	$ * (57,194)	39

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

STATE OF ILLINOIS

Facility Name & ID Number Kewanee Care Home # 0053132 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 V	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care X	Peoria	Lessor	13
14			Decatur Rehab & Health Care Center	Decatur	Midwest Health Opera	Peoria	Mgmt/Bookkeeping	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Health Prope	Peoria	Mgmt/Bookkeeping	15
16			Eastview Terrace	Sullivan	Petersen Roseville, LL	Roseville	Lessor	16
17			El Paso Health Care Center	El Paso	Petersen Health Juncti	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Petersen Health Qualit	Peoria	Mgmt/Bookkeeping	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Health and W	Peoria	Mgmt/Bookkeeping	19
20			Flanagan Rehab & Health Care Center	Flanagan	Petersen 24, LLC	Peoria	Hospitality	20
21			Flora Gardens Care Center	Flora				21
22			Flora Health Care Center	Flora				22
23			Fondulac Rehab & Health Care Center	East Peoria				23
24			Havana Health Care Center	Havana				24
25			Illini Heritage Rehab & Health Care	Champaign				25
26			Jonesboro Rehab & Health Care Center	Jonesboro				26
27			Kewanee Care Home	Kewanee				27
28			LaHarpe Davier Health Care Center	LaHarpe				28
29			Lebanon Care Center	Lebanon				29
30			Marigold Rehab & Health Care Center	Galesburg				30

Facility Name & ID Number Kewanee Care Home # 0053132 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 Kewanee Care Home # 0053132 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
					Compensation Received From Other	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
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 Kewanee Care Home # 0053132 Report Period Beginning: 1/1/2018 Ending: 2/31/2018

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	1,411,762	75	$ 342,871	$ 393,211	24,477	$ 5,945	1
2	2	Food	Resident Days	1,411,762	75	3,216	0	24,477	56	2
3	3	Housekeeping	Resident Days	1,411,762	75	5,441	2,652	24,477	94	3
4	5	Utilities	Resident Days	1,411,762	75	17,524	0	24,477	304	4
5	6	Maintenance	Resident Days	1,411,762	75	134,460	148,272	24,477	2,331	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,411,762	75	0	0	24,477	0	6
7	9	Medical Director	Resident Days	1,411,762	75	0	0	24,477	0	7
8	10	Nursing and Medical Records	Resident Days	1,411,762	75	237,275	1,454,984	24,477	4,114	8
9	10A	Therapy	Resident Days	1,411,762	75	0	0	24,477	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,411,762	75	0	0	24,477	0	10
11	17	Administrative	Resident Days	1,411,762	75	4,940,583	5,658,897	24,477	78,077	11
12	19	Professional Services	Resident Days	1,411,762	75	1,037,806	0	24,477	17,993	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,411,762	75	254,355	0	24,477	4,410	13
14	21	Clerical and General Office	Resident Days	1,411,762	75	3,518,216	3,764,024	24,477	60,999	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,411,762	75	1,477,639	0	24,477	25,619	15
16	23	Inservice Training & Education	Resident Days	1,411,762	75	8,601	0	24,477	149	16
17	24	Travel and Seminar	Resident Days	1,411,762	75	174	0	24,477	3	17
18	25	Other Admin. Staff Transport.	Resident Days	1,411,762	75	261,018	0	24,477	4,526	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,411,762	75	65,437	0	24,477	1,135	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,411,762	75	832,087	0	24,477	14,427	20
21	30	Depreciation	Resident Days	1,411,762	75	7,528	0	24,477	131	21
22	32	Interest	Resident Days	1,411,762	75	218,814	0	24,477	3,794	22
23	33	Real Estate Taxes	Resident Days	1,411,762	75	25,901	0	24,477	449	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,411,762	75	75,380	0	24,477	1,307	24
25	TOTALS					$ 13,464,326	$ 11,422,040		$ 225,863	25

Facility Name & ID Number Kewanee Care Home # 0053132 Report Period Beginning: 1/1/2018 Ending: 2/31/2018

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	59,127	2	$	$	24,477	$	1
2	2	Food	Resident Days	59,127	2			24,477		2
3	3	Housekeeping	Resident Days	59,127	2			24,477		3
4	4	Laundry	Resident Days	59,127	2			24,477		4
5	5	Utilities	Resident Days	59,127	2			24,477		5
6	6	Maintenance	Resident Days	59,127	2			24,477		6
7	7	Mgmt. Allocation of Benefits	Resident Days	59,127	2			24,477		7
8	10	Nursing and Medical Records	Resident Days	59,127	2			24,477		8
9	15	Mgmt. Allocation of Benefits	Resident Days	59,127	2			24,477		9
10	17	Administrative	Resident Days	59,127	2			24,477		10
11	19	Professional Services	Resident Days	59,127	2	2,475		24,477	1,025	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	59,127	2			24,477		12
13	21	Clerical and General Office	Resident Days	59,127	2			24,477		13
14	22	Employee Benefits & Payroll	Resident Days	59,127	2			24,477		14
15	23	Inservice Training & Education	Resident Days	59,127	2			24,477		15
16	24	Travel and Seminar	Resident Days	59,127	2			24,477		16
17	25	Other Admin. Staff Transport.	Resident Days	59,127	2			24,477		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	59,127	2			24,477		18
19	30	Depreciation	Resident Days	59,127	2			24,477		19
20	31	Amortization	Resident Days	59,127	2			24,477		20
21	32	Interest	Resident Days	59,127	2	133,077		24,477	55,090	21
22	33	Real Estate Taxes	Resident Days	59,127	2			24,477		22
23	34	Rent-Facility and Grounds	Resident Days	59,127	2			24,477		23
24	35	Rent-Equipment & Vehicles	Resident Days	59,127	2			24,477		24
25	TOTALS					$ 135,552	$		$ 56,115	25

Facility Name & ID Number Kewanee Care Home # 0053132 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		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	Capital Finance Group		X	Mortgage	Varies	1/1/14	$ 3,870,400	$ 3,453,921	12/31/39	Varies	$ 134,862	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 3,870,400	$ 3,453,921			$ 134,862	9
	B. Non-Facility Related*											
10								Interest Income Offset			(3,399)	10
11								Home Office Allocation-PHCM			3,794	11
12								Home Office Allocation-PHJ			79,438	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 79,833	14
15	TOTALS (line 9+line14)						$ 3,870,400	$ 3,453,921			$ 214,695	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 22,767 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.)

Facility Name & ID Number Kewanee Care Home # 0053132 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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

B. Real Estate Taxes

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

Item		Amount	Line
1. Real Estate Tax accrual used on 2017 report.	$	57,180	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	58,315	2
3. Under or (over) accrual (line 2 minus line 1).	$	1,135	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)	$	60,060	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **Home Office Allocation** 449 **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	61,644	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

Year	Amount	Line
2013	53,223	8
2014	53,558	9
2015	55,602	10
2016	55,509	11
2017	58,315	12

Accrual based on prior year tax bill.

FOR BHF USE ONLY

Line	Description		Line
13	FROM R. E. TAX STATEMENT FOR 2017	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Kewanee Care Home COUNTY Henry

FACILITY IDPH LICENSE NUMBER 0053132

CONTACT PERSON REGARDING THIS REPORT MIKE KOCHER

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

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

Enter the tax index number and real estate tax assessed for 2017 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	25-05-281-017	901 W. Mill St.	$ 128.46	$ 128.46
2.	25-04-151-011	144 Junior Ave.	$ 58,089.16	$ 58,089.16
3.	25-04-152-001	821 Dewey Ave.	$ 97.50	$ 97.50
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 58,315.12	$ 58,315.12

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: 12,548 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

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

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

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

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

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

N/A

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

1. Total Amount Incurred: 228,631
2. Number of Years Over Which it is Being Amortized: 25
3. Current Period Amortization: 9,276
4. Dates Incurred: 2013-2014

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	42,000	1976	$ 25,000	1
2	Facility	11,250	1992	25,621	2
3	TOTALS	53,250		$ 50,621	3

Facility Name & ID Number Kewanee Care Home # 0053132 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1976		$ 381,128	$	30	$	$	$ 381,128	4
5			1998	1998	753,696		40	18,842	18,842	388,315	5
6			2002	2002	661,677		40	16,542	16,542	242,766	6
7											7
8											8
	Improvement Type**										
9	1984-1997 Fully Depreciated Assets				227,433					227,433	9
10	New sign			1998	7,304		20			7,304	10
11	Landscaping			1998	21,500		20	358	358	21,500	11
12	Duct Work-New Wing			1999	1,494		20	75	75	1,462	12
13	Tiling			1999	914		20	46	46	897	13
14	Water Heater			1999	2,835		20			2,835	14
15	Water Heater			1999	3,766		20	188	188	3,666	15
16	Cubicle Partitions			1999	701		20	35	35	682	16
17	Beauty Salon			2000	943		20	47	47	870	17
18	Tile Flooring			2000	10,219		20	511	511	9,511	18
19	Lot/House Razed			2000	5,061		20			5,061	19
20	Concrete			2001	900		15			900	20
21	Landscaping			2001	1,045		15			1,045	21
22	Lighting			2001	3,438		39	88	88	1,584	22
23	Blinds/Curtains			2001	9,500		7			9,500	23
24	Landscaping			2002	24,614		15			24,614	24
25	Landscaping			2002	4,075		15			4,075	25
26	Architectural			2002	15,602		20			15,602	26
27	Carpeting			2002	2,551		20	128	128	2,112	27
28	Fire System			2002	4,677		20	234	234	3,861	28
29	Landscaping			2003	4,899		15	158	158	4,899	29
30	Simplex Time Clock			2004	3,198		10			3,198	30
31	Air Conditioner			2004	2,700		10			2,700	31
32	Side walks			2005	2,065		15	138	138	1,932	32
33	Floor covering			2005	13,891		7			13,891	33
34	Flooring			2006	28,527		25	1,141	1,141	14,263	34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Kewanee Care Home # 0053132 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Driveway	2007	7,101		15	473	$ 473	$ 5,440	37
38	Boiler	2007	2,895		10			2,895	38
39	Sprinkler System Repair	2008	2,583		5			2,583	39
40	Painting of Dining Room	2008	2,825		39	72	72	756	40
41	Sprinkler System Repair	2008	2,689		5			2,689	41
42	Fencing	2009	3,400		15	226	226	2,147	42
43	Boiler	2010	2,900		20	146	146	1,241	43
44	Compressor Repair	2010	2,639		7	289	289	2,639	44
45	Dry Pendent Head Replacement	2011	8,857		7	628	628	8,857	45
46	Compressor	2012	2,685		7	384	384	2,496	46
47	Air Conditioner-Central System	2012	2,978		15	198	198	1,287	47
48	Furnace, Air Conditoner, and Boiler	2012	17,929		15	1,195	1,195	9,604	48
49	A/C Repair	2013	3,455		7	494	494	2,717	49
50	Water Pipe Repair	2013	5,861		7	838	838	4,609	50
51	Smoke and Heat	2014	2,742		7	392	392	1,764	51
52	Alarm System	2014	4,344		7	621	621	2,795	52
53	Water Line Repair	2014	2,712		7	387	387	1,742	53
54	Water Pipe Repair	2014	2,550		7	364	364	1,638	54
55	Water Line Repair	2014	3,860		7	551	551	2,480	55
56	Boiler	2014	3,552		15	237	237	1,067	56
57	Dry Pendent Head Replacement	2015	3,973		7	568	568	1,988	57
58	Roof Replacement	2015	110,000		25	4,450	4,450	15,575	58
59	Repair and Reseal of Parking Lot	2016	20,930		15	1,396	1,396	3,490	59
60	Water Pipe Repair	2016	5,157		7	736	736	1,840	60
61	Air Conditioner	2016	6,368		15	424	424	1,060	61
62	Nurse Call System Replacement	2016	5,988		7	856	856	2,140	62
63	Tiling/Carpeting-6 Shower Rooms, 11 Patient Rooms, Halls	2016	97,105		15	6,474	6,474	16,185	63
64	Sprinkler Repair	2017	2,855		7	408	408	612	64
65	Furnace and Boiler Repair	2018	2,535		7	181	181	181	65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,543,821	$		$ 61,519	$ 61,519	$ 1,502,123	70

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

Facility Name & ID Number Kewanee Care Home # 0053132 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,543,821	$		$ 61,519	$ 61,519	$ 1,502,123	1
2									2
3									3
4									4
5									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	Land Improvements Booked			2,828			(2,828)		26
27	Building Booked			19,325			(19,325)		27
28	Building Improvement Booked			50,085			(50,085)		28
29									29
30	2018-Home Office Allocation-Building Improvements		11,513			276	276		30
31	2018-Home Office Allocation-Land Improvements		1,155			73	73		31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,556,489	$ 72,238		$ 61,868	$ (10,370)	$ 1,502,123	34

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

Facility Name & ID Number: Kewanee Care Home # 0053132 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	$ 45,590	$ 4,358	$ 4,861	$ 503	5-10 yrs.	$ 28,579	71
72	Current Year Purchases	11,302	656	808	152	7 yrs.	808	72
73	Fully Depreciated Assets	200,479					200,479	73
74	Home Office Allocation			14,078	14,078			74
75	TOTALS	$ 257,371	$ 5,014	$ 19,747	$ 14,733		$ 229,866	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	2000 Town & Country	2002	35,088	$	$	$		$ 35,088	76
77										77
78										78
79										79
80	TOTALS			$ 35,088	$	$	$		$ 35,088	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,899,569	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 77,252	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 81,615	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 4,363	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,767,077	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 Kewanee Care Home # 0053132 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

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

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2019	$
13.	/2020	$
14.	/2021	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 41,776 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.

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

Kewanee Care Home
0053132
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	$ 37,799
Dishwasher	1,211
Copier	1,459
Home Office Allocation	1,307
	41,776

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A(3)	hrs	$	13,916	$ 208,736	$	13,916	$ 208,736	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2,759	41,384		2,759	41,384	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		15,645	234,673		15,645	234,673	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				79,074		79,074	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			$	32,320	$ 484,793	$ 79,074	32,320	$ 563,867	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 Kewanee Care Home # 0053132 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2018 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,962,939	$ 2,962,939	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 219,514)	1,629,599	1,629,599	3
4	Supply Inventory (priced at Cost)	12,965	12,965	4
5	Short-Term Investments			5
6	Prepaid Insurance	21,566	40,556	6
7	Other Prepaid Expenses	163,154	194,641	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Interco. Loans & Emp. Loans	129,907	161,278	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,920,130	$ 5,001,978	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		50,621	13
14	Buildings, at Historical Cost		1,808,014	14
15	Leasehold Improvements, at Historical Cost	3,552	748,475	15
16	Equipment, at Historical Cost	38,211	292,459	16
17	Accumulated Depreciation (book methods)	(36,446)	(1,767,077)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		228,631	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(38,868)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spe Const. In Progress		37,248	22
23	Other(specify): Fund Balance Reserves		308,360	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 5,317	$ 1,667,863	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,925,447	$ 6,669,841	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,032,632	$ 1,042,507	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	96,609	96,609	30
31	Accrued Taxes Payable (excluding real estate taxes)	382,779	382,779	31
32	Accrued Real Estate Taxes(Sch.IX-B)		60,060	32
33	Accrued Interest Payable		11,081	33
34	Deferred Compensation	5,852	5,852	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	466	466	36
37	Accrued Management Fees			37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,518,338	$ 1,599,354	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,453,921	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Intercompany Loans	1,853,719	9,624	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,853,719	$ 3,463,545	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,372,057	$ 5,062,899	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,553,390	$ 1,606,942	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,925,447	$ 6,669,841	48

*(See instructions.)

Facility Name & ID Number Kewanee Care Home # 0053132 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 415,758	1
2	Restatements (describe):		2
3	Rounding	2	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 415,760	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,137,630	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)**	$ 1,137,630	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)**	$ 1,553,390	24 *

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

Facility Name & ID Number Kewanee Care Home # 0053132 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,085,075	1
2	Discounts and Allowances for all Levels	(274,931)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,810,144	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	928,244	6
7	Oxygen	5,970	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 934,214	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	5,889	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	161,185	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	19,332	20
21	Other Medical Services	22,729	21
22	Laundry	348	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 209,483	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,597	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,597	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Transportation Revenue	17,027	28
28a	Miscellaneous Revenue	763	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 17,790	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,974,228	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	624,779	31
32	Health Care	1,867,176	32
33	General Administration	600,015	33
	B. Capital Expense		
34	Ownership	424,532	34
	C. Ancillary Expense		
35	Special Cost Centers	145,936	35
36	Provider Participation Fee	174,160	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,836,598	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,137,630	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,137,630	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,158,052	44
45	Private Pay - Net Inpatient Revenue	817,587	45
46	Medicare - Net Inpatient Revenue	775,854	46
47	Other-(specify) Insurance Net Inpatient Revenue	58,651	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,810,144	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 Kewanee Care Home # 0053132 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	2,080	2,080	$ 67,500	$ 32.45	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,759	4,965	114,656	23.09	3
4	Licensed Practical Nurses	13,940	14,465	313,419	21.67	4
5	CNAs & Orderlies	48,285	49,474	534,080	10.80	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,040	2,040	27,710	13.58	9
10	Activity Assistants	175	175	1,755	10.03	10
11	Social Service Workers	2,080	2,080	31,292	15.04	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	28,298	13.60	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,105	13,540	124,537	9.20	15
16	Dishwashers					16
17	Maintenance Workers	1,926	1,986	34,650	17.45	17
18	Housekeepers	8,981	9,272	101,399	10.94	18
19	Laundry	5,335	5,495	50,831	9.25	19
20	Administrator	2,000	2,080	78,077	37.54	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,896	1,947	32,572	16.73	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	197	213	2,632	12.36	31
32	Other Health Care(specify)					32
33	Other(specify) Page 20A	6,737	6,822	136,056	19.94	33
34	TOTAL (lines 1 - 33)	115,616	118,714	$ 1,679,464 *	$ 14.15	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	12,000	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,617	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 18,617		49

C. CONTRACT NURSES

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

Kewanee Care Home
0053132
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	2,874	2,959	81,922	27.69
Transportation	1,513	1,513	25,539	16.88
Marketing	2,350	2,350	28,595	12.17
TOTAL	6,737	6,822	136,056	

Facility Name & ID Number Kewanee Care Home # 0053132 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Christina Walker	Administrator	0	$ 4,202
Sasha Wilson	Administrator	0	73,875
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 78,077

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 333,500
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 333,500

C. Professional Services

Vendor/Payee	Type	Amount
ProTitle USA	Legal Fees	$ 441
Comcast Communications	Computer Services	1,199
Ability Network	Computer Services	1,073
Peoples National Bank	Legal Fees	348
Henry County Circuit Clerk	Legal Filing Fees	100
Schroeder-Greer Appraisal	Appraisal Fees	200
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 3,361

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 22,203
Unemployment Compensation Insurance	19,008
FICA Taxes	121,663
Employee Health Insurance	2,178
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	1,269
Home Office Allocation	25,619
Employee Retirement	150
TOTAL (agree to Schedule V, line 22, col.8)	$ 192,090

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

Description	Line #	Amount
N/A		
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	
Health Care Worker Background Check (Indicate # of checks performed 15)	450
Patient Background Checks	1,696
Miscellaneous Licenses & Permits	608
Miscellaneous Dues & Subscriptions	275
Home Office Allocation	4,410
Less: Public Relations Expense	(275)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,144

G. Schedule of Travel and Seminar**

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

**See instructions.

Kewanee Care Home
0053132

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)		3,361
Home Office Allocation		
Duane Morris	Legal	2460
Sedgwick CMS	Legal	218
SB2	Legal	607
Miscellaneous	Legal	181
Christoper P. Ryan	Legal	192
Saul Ewing Arnstein & Lehr	Legal	861
Healthcare Resources International	Legal	129
Winston & Strawn	Legal	2073
Lexis Nexis	Legal	9
Pretzel & Stouffer	Legal	30
Miller Hall and Triggs	Legal	1906
Capitol Finance Group	Legal	250
CliftonLarsonAllen	Accounting	1258
Ginoli & Co.	Accounting	4920
Duane Morris	Accounting	73
Getzler Henrich & Associates	Accounting	966
Kemper Consulting	Accounting	73
Baker Tilly Virchow Krause	Accounting	509
Capitol Finance Group	Accounting	4930
Miscellaneous	Computer Services	134
Change Healthcare	Computer Services	4
TR Professional	Computer Services	13
Matrix Care	Computer Services	1413
Ability Network	Computer Services	2237
Stratus Networks	Computer Services	547
Kemper Technology	Computer Services	628
AT&T	Computer Services	7
Ungerboeck Software	Computer Services	452
CIAN	Computer Services	196
Comcast	Computer Services	49
CCH	Computer Services	18
Charter Communications	Computer Services	33
Allscripts	Computer Services	636
ATS	Computer Services	295
Citrix Systems	Computer Services	103
Optimizer	Other Prof Fees	57
Sedgwick CLMS	Other Prof Fees	199
David Budde	Other Prof Fees	57
Sargent Consulting	Other Prof Fees	22613
Alix Partners	Other Prof Fees	12420
Getzler Henrich & Associates	Other Prof Fees	81
Total (agree to Schedule V, line 19, column 8)		67,198

Kewanee Care Home
0053132
Period Beginning 1/1/2018
Period End 12/31/2018

Schedule 14A

25. Adminsrative and Staff Transportation

Gas	$ 11,763
Auto Repairs	5,545
Mileage-Travel	4,687
Home Office Allocation	4,526
	26,521

Facility Name & ID Number Kewanee Care Home # 0053132 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA-**

(3) Did the nursing home make political contributions or payments to a 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. $ **26,060** 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. $ **174,160**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **5,889**

(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. $ **17,027**

c. What percent of all travel expense relates to transportation of nurses and patients? **100**

d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**

e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**

g. Does the facility transport residents to and from day training? **No**
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Ginoli and Company**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **No**
Attach invoices and a summary of services for all architect and appraisal fees