

Facility Name & ID Number Nokomis Rehab & Health Care Center

0050641 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	92	Skilled (SNF)	92	33,580	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	92	TOTALS	92	33,580	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	10,035	2,496	1,041	13,572	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,035	2,496	1,041	13,572	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 40.42%

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)
Meals on Wheels

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 8/1/2007

J. Was the facility purchased or leased after January 1, 1978?
YES Date 8/1/2007 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 92 and days of care provided 969

Medicare Intermediary CGS Administrators

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 Nokomis Rehab & Health Care Center # 0050641 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	131,597	11,042	1,143	143,782		143,782	3,296	147,078		1
2	Food Purchase		100,988		100,988		100,988	(3,113)	97,875		2
3	Housekeeping	79,276	14,652		93,928		93,928	52	93,980		3
4	Laundry	51,899	11,967		63,866		63,866		63,866		4
5	Heat and Other Utilities			67,386	67,386		67,386	168	67,554		5
6	Maintenance	41,203	8,475	17,709	67,387		67,387	1,293	68,680		6
7	Other (specify):* <u>Home Office Ben. Allocation</u>										7
8	TOTAL General Services	303,975	147,124	86,238	537,337		537,337	1,696	539,033		8
	B. Health Care and Programs										
9	Medical Director			15,000	15,000		15,000		15,000		9
10	Nursing and Medical Records	767,312	59,308	6,786	833,406		833,406	2,281	835,687		10
10a	Therapy			109,022	109,022		109,022		109,022		10a
11	Activities	33,494	229	317	34,040		34,040	(9,898)	24,142		11
12	Social Services	37,727	51		37,778		37,778		37,778		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Office Ben. Allocation</u>										15
16	TOTAL Health Care and Programs	838,533	59,588	131,125	1,029,246		1,029,246	(7,617)	1,021,629		16
	C. General Administration										
17	Administrative			178,800	178,800		178,800	(118,133)	60,667		17
18	Directors Fees										18
19	Professional Services			11,039	11,039		11,039	5,524	16,563		19
20	Dues, Fees, Subscriptions & Promotions			3,456	3,456		3,456	2,445	5,901		20
21	Clerical & General Office Expenses	22,130	2,612	7,326	32,068		32,068	33,762	65,830		21
22	Employee Benefits & Payroll Taxes			125,492	125,492		125,492	14,205	139,697		22
23	Inservice Training & Education							83	83		23
24	Travel and Seminar							2	2		24
25	Other Admin. Staff Transportation			8,875	8,875		8,875	2,509	11,384		25
26	Insurance-Prop.Liab.Malpractice			28,609	28,609		28,609	629	29,238		26
27	Other (specify):* <u>Home Office Ben. Allocation</u>										27
28	TOTAL General Administration	22,130	2,612	363,597	388,339		388,339	(58,974)	329,365		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,164,638	209,324	580,960	1,954,922		1,954,922	(64,895)	1,890,027		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 Nokomis Rehab & Health Care Center

#0050641

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

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			69,390	69,390		69,390	6,966	76,356			30
31	Amortization of Pre-Op. & Org.							7,178	7,178			31
32	Interest			48,581	48,581		48,581	10,709	59,290			32
33	Real Estate Taxes			54,762	54,762		54,762	249	55,011			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			8,349	8,349		8,349	725	9,074			35
36	Other (specify):*											36
37	TOTAL Ownership			181,082	181,082		181,082	25,827	206,909			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		28,221		28,221		28,221		28,221			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			126,330	126,330		126,330		126,330			42
43	Other (specify):* Miscellaneous		1,045	149,902	150,947		150,947	(150,947)				43
44	TOTAL Special Cost Centers		29,266	276,232	305,498		305,498	(150,947)	154,551			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,164,638	238,590	1,038,274	2,441,502		2,441,502	(190,015)	2,251,487			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	(2,562)	2		4
5	Telephone, TV & Radio in Resident Rooms	(471)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(1,033)	30		9
10	Interest and Other Investment Income	(3,755)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(174)	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	(116,564)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(8,244)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(26,000)	43		24
25	Fund Raising, Advertising and Promotional	(953)	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	(17,325)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (177,081)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(12,934)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (12,934)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (190,015)		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	

Nokomis Rehab & Health Care Center

ID# 0050641

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (3,190)	43	1
2	X-Rays-Part A	(2,424)	43	2
3	Disallowed Special Events	(932)	43	3
4	Offset Transportation Revenue	(9,898)	11	4
5	Offset Miscellaneous Office Supplies	(60)	21	5
6	Disallowed Resident Flower	(239)	43	6
7	Disallowed Meals On Wheels Revenue	(582)	2	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
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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	(17,325)		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:	
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)	
1	V	1 Dietary	\$	Petersen Health Care Management, Inc.	100.00%	\$ 3,296	\$ 3,296	1
2	V	2 Food		Petersen Health Care Management, Inc.	100.00%	31	31	2
3	V	3 Housekeeping		Petersen Health Care Management, Inc.	100.00%	52	52	3
4	V	5 Utilities		Petersen Health Care Management, Inc.	100.00%	168	168	4
5	V	6 Maintenance		Petersen Health Care Management, Inc.	100.00%	1,293	1,293	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%	2,281	2,281	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	106,800	Petersen Health Care Management, Inc.	100.00%	60,667	(46,133)	11
12	V	19 Professional Services		Petersen Health Care Management, Inc.	100.00%	9,977	9,977	12
13	V							13
14	Total		\$ 106,800			\$ 77,765	\$ * (29,035)	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%	\$ 2,445	\$	2,445	15
16	V	21 <u>Clerical and General Office</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	33,822		33,822	16
17	V	22 <u>Employee Benefits and Payroll Taxes</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	14,205		14,205	17
18	V	23 <u>Inservice Training & Education</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	83		83	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%	2,509		2,509	20
21	V	26 <u>Insurance-Prop./Liab./Malprac.</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	629		629	21
22	V	30 <u>Depreciation</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	7,999		7,999	22
23	V	31 <u>Amortization</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	72		72	23
24	V	32 <u>Interest</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	2,104		2,104	24
25	V	33 <u>Real Estate Taxes</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	249		249	25
26	V	35 <u>Rent-Equipment & Vehicles</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	725		725	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		\$			\$ 64,844	\$ *	64,844	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 Dietary	\$	Petersen Health Network, LLC	100.00%	\$ 0	\$	15
16	V	2 Food		Petersen Health Network, LLC	100.00%	0		16
17	V	3 Housekeeping		Petersen Health Network, LLC	100.00%	0		17
18	V	4 Laundry		Petersen Health Network, LLC	100.00%	0		18
19	V	5 Utilities		Petersen Health Network, LLC	100.00%	0		19
20	V	6 Maintenance		Petersen Health Network, LLC	100.00%	0		20
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Network, LLC	100.00%	0		21
22	V	10 Nursing and Medical Records		Petersen Health Network, LLC	100.00%	0		22
23	V	15 Mgmt. Allocation of Benefits		Petersen Health Network, LLC	100.00%	0		23
24	V	17 Administrative	72,000	Petersen Health Network, LLC	100.00%	0	(72,000)	24
25	V	19 Professional Services		Petersen Health Network, LLC	100.00%	3,791	3,791	25
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Network, LLC	100.00%	0		26
27	V	21 Clerical and General Office		Petersen Health Network, LLC	100.00%	0		27
28	V	22 Employee Benefits & Payroll		Petersen Health Network, LLC	100.00%	0		28
29	V	23 Inservice Training & Education		Petersen Health Network, LLC	100.00%	0		29
30	V	24 Travel and Seminar		Petersen Health Network, LLC	100.00%	0		30
31	V	25 Other Admin. Staff Transport.		Petersen Health Network, LLC	100.00%	0		31
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Network, LLC	100.00%	0		32
33	V	30 Depreciation		Petersen Health Network, LLC	100.00%	0		33
34	V	31 Amortization		Petersen Health Network, LLC	100.00%	7,106	7,106	34
35	V	32 Interest		Petersen Health Network, LLC	100.00%	12,360	12,360	35
36	V	33 Real Estate Taxes		Petersen Health Network, LLC	100.00%	0		36
37	V	34 Rent-Facility and Grounds		Petersen Health Network, LLC	100.00%	0		37
38	V	35 Rent-Equipment & Vehicles		Petersen Health Network, LLC	100.00%	0		38
39	Total		\$ 72,000			\$ 23,257	\$ * (48,743)	39

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

Facility Name & ID Number

Nokomis Rehab & Health Care Center

0050641

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

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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 Nokomis Rehab & Health Care Center # 0050641 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 Nokomis Rehab & Health Care Center

0050641

Report Period Beginning:

1/1/2018

Ending: 2/31/2018

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,411,762	75	\$ 342,871	\$ 393,211	13,572	\$ 3,296	1
2	2	Food	Resident Days	1,411,762	75	3,216	0	13,572	31	2
3	3	Housekeeping	Resident Days	1,411,762	75	5,441	2,652	13,572	52	3
4	5	Utilities	Resident Days	1,411,762	75	17,524	0	13,572	168	4
5	6	Maintenance	Resident Days	1,411,762	75	134,460	148,272	13,572	1,293	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,411,762	75	0	0	13,572	0	6
7	9	Medical Director	Resident Days	1,411,762	75	0	0	13,572	0	7
8	10	Nursing and Medical Records	Resident Days	1,411,762	75	237,275	1,454,984	13,572	2,281	8
9	10A	Therapy	Resident Days	1,411,762	75	0	0	13,572	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,411,762	75	0	0	13,572	0	10
11	17	Administrative	Resident Days	1,411,762	75	4,940,583	5,658,897	13,572	60,667	11
12	19	Professional Services	Resident Days	1,411,762	75	1,037,806	0	13,572	9,977	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,411,762	75	254,355	0	13,572	2,445	13
14	21	Clerical and General Office	Resident Days	1,411,762	75	3,518,216	3,764,024	13,572	33,822	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,411,762	75	1,477,639	0	13,572	14,205	15
16	23	Inservice Training & Education	Resident Days	1,411,762	75	8,601	0	13,572	83	16
17	24	Travel and Seminar	Resident Days	1,411,762	75	174	0	13,572	2	17
18	25	Other Admin. Staff Transport.	Resident Days	1,411,762	75	261,018	0	13,572	2,509	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,411,762	75	65,437	0	13,572	629	19
20	30	Depreciation	Resident Days	1,411,762	75	832,087	0	13,572	7,999	20
21	31	Amortization	Resident Days	1,411,762	75	7,528	0	13,572	72	21
22	32	Interest	Resident Days	1,411,762	75	218,814	0	13,572	2,104	22
23	33	Real Estate Taxes	Resident Days	1,411,762	75	25,901	0	13,572	249	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,411,762	75	75,380	0	13,572	725	24
25	TOTALS					\$ 13,464,326	\$ 11,422,040		\$ 142,609	25

Facility Name & ID Number Nokomis Rehab & Health Care Center

0050641

Report Period Beginning:

1/1/2018

Ending: 2/31/2018

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	230,518	13	\$	\$	13,572	\$	1
2	2	Food	Resident Days	230,518	13			13,572		2
3	3	Housekeeping	Resident Days	230,518	13			13,572		3
4	4	Laundry	Resident Days	230,518	13			13,572		4
5	5	Utilities	Resident Days	230,518	13			13,572		5
6	6	Maintenance	Resident Days	230,518	13			13,572		6
7	7	Mgmt. Allocation of Benefits	Resident Days	230,518	13			13,572		7
8	10	Nursing and Medical Records	Resident Days	230,518	13			13,572		8
9	15	Mgmt. Allocation of Benefits	Resident Days	230,518	13			13,572		9
10	17	Administrative	Resident Days	230,518	13			13,572		10
11	19	Professional Services	Resident Days	230,518	13	64,384		13,572	3,791	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	230,518	13			13,572		12
13	21	Clerical and General Office	Resident Days	230,518	13			13,572		13
14	22	Employee Benefits & Payroll	Resident Days	230,518	13			13,572		14
15	23	Inservice Training & Education	Resident Days	230,518	13			13,572		15
16	24	Travel and Seminar	Resident Days	230,518	13			13,572		16
17	25	Other Admin. Staff Transport.	Resident Days	230,518	13			13,572		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	230,518	13			13,572		18
19	30	Depreciation	Resident Days	230,518	13			13,572		19
20	31	Amortization	Resident Days	230,518	13	120,699		13,572	7,106	20
21	32	Interest	Resident Days	230,518	13	209,925		13,572	12,360	21
22	33	Real Estate Taxes	Resident Days	230,518	13			13,572		22
23	34	Rent-Facility and Grounds	Resident Days	230,518	13			13,572		23
24	35	Rent-Equipment & Vehicles	Resident Days	230,518	13			13,572		24
25	TOTALS					\$ 395,008	\$		\$ 23,257	25

Facility Name & ID Number

Nokomis Rehab & Health Care Center

0050641

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	Wells Fargo		X	Mortgage	Varies	1/1/2015	\$ 892,857	\$ 723,214	12/31/34	Varies	\$ 48,581	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6												6						
7												7						
8												8						
9	TOTAL Facility Related						\$ 892,857	\$ 723,214			\$ 48,581	9						
B. Non-Facility Related*																		
10									Interest Income Offset		(3,755)	10						
11									Home Office Allocation-PHN		12,360	11						
12									Home Office Allocation-PHCM		2,104	12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ 10,709	14						
15	TOTALS (line 9+line14)						\$ 892,857	\$ 723,214			\$ 59,290	15						

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

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

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

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Nokomis Rehab & Health Care Center COUNTY Montgomery

FACILITY IDPH LICENSE NUMBER 0050641

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>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>08-23-276-016</u>	<u>Long-Term Care Facility</u>	\$ <u>54,953.68</u>	\$ <u>54,953.68</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>54,953.68</u></u>	\$ <u><u>54,953.68</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: 32,807 B. General Construction Type: Exterior Brick Frame Steel & Brick Number of Stories 1

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

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

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

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

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

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

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

If so, please complete the following:

1. Total Amount Incurred: 561,304 2. Number of Years Over Which it is Being Amortized: 20

3. Current Period Amortization: 7,178 4. Dates Incurred: 2013-2014

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>217,800</u>	<u>2007</u>	<u>\$ 60,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	217,800		\$ 60,000	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	92	2007	1970	1,200,000		25	48,000	\$ 48,000	\$ 552,000
5									
6									
7									
8									
Improvement Type**									
9	Water Heater		2008	10,490		10	1,050	1,050	9,975
10	Smoke Detector		2009	2,799		7			2,799
11	Carpet		2010	2,652		15	177	177	1,416
12	Roof Repair		2010	9,362		7	671	671	9,362
13	Roof Repair-Front Entry Area		2011	5,753		25	230	230	1,495
14	Roof Repair		2012	2,875		7	410	410	2,255
15	Sprinkler System Replacement		2013	114,950		25	4,598	4,598	25,289
16	Roof Replacement		2014	44,203		25	1,768	1,768	7,941
17	Air Conditioner		2017	22,640		15	1,510	1,510	2,265
18	Compressor Repair		2017	4,265		7	610	610	915
19	Water Heater		2018	8,523		15	284	284	284
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31	Building Booked				48,000			(48,000)	
32	Building Improvement Booked				11,708			(11,708)	
33									
34	2018-Home Office Allocation-Building Improvements			6,384			153	153	
35	2018-Home Office Allocation-Land Improvements			640			41	41	
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 Nokomis Rehab & Health Care Center

0050641

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	\$ 86,116	\$ 9,644	\$ 8,823	\$ (821)	5-10 yrs.	\$ 49,263	71
72	Current Year Purchases	3,172	38	226	188	7 yrs.	226	72
73	Fully Depreciated Assets	143,777					143,777	73
74	Home Office Allocation			7,805	7,805			74
75	TOTALS	\$ 233,065	\$ 9,682	\$ 16,854	\$ 7,172		\$ 193,266	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)	\$ 1,728,601	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 69,390	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 76,356	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 6,966	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 809,262	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 Nokomis Rehab & Health Care Center

0050641

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.

YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12.	_____ /2019	\$ _____
13.	_____ /2020	\$ _____
14.	_____ /2021	\$ _____

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

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

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

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

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ 9,074 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.

Nokomis Rehab & Health Care Center

0050641

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	\$	5,174
Dishwasher		839
Copier		2,336
Home Office Allocation		725
		<u>9,074</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	\$	2,904	\$ 43,556	\$	2,904	\$ 43,556	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,479	22,186		1,479	22,186	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		2,885	43,280		2,885	43,280	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescripts				28,221		28,221	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			\$	7,268	\$ 109,022	\$ 28,221	7,268	\$ 137,243	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.

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	\$ (861,398)	\$ (861,398)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>100,253</u>)	1,069,720	1,069,720	3
4	Supply Inventory (priced at <u>Cost</u>)	7,357	7,357	4
5	Short-Term Investments			5
6	Prepaid Insurance	17,589	17,589	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 233,268	\$ 233,268	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	60,000	60,000	13
14	Buildings, at Historical Cost	1,200,000	1,206,384	14
15	Leasehold Improvements, at Historical Cost	228,512	229,152	15
16	Equipment, at Historical Cost	233,065	233,065	16
17	Accumulated Depreciation (book methods)	(823,877)	(809,262)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 897,700	\$ 919,339	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,130,968	\$ 1,152,607	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 492,287	\$ 492,287	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	51,696	51,696	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,452	5,452	31
32	Accrued Real Estate Taxes(Sch.IX-B)	56,604	56,604	32
33	Accrued Interest Payable	4,265	4,265	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	39,583	39,583	36
37	<u>Accrued Management Fees</u>	221	221	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 650,108	\$ 650,108	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	723,214	723,214	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Intercompany Loans</u>	126,397	126,397	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 849,611	\$ 849,611	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,499,719	\$ 1,499,719	46
47	TOTAL EQUITY(page 18, line 24)	\$ (368,751)	\$ (347,112)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,130,968	\$ 1,152,607	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (66,818)	1
2	Restatements (describe):		2
3	Adjustments Made After Cost Reports Were Filed	(1,108)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (67,926)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(300,825)	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)	\$ (300,825)	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)	\$ (368,751)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Nokomis Rehab & Health Care Center

0050641

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 1,974,323	1
2	Discounts and Allowances for all Levels	(151,751)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,822,572	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	218,922	6
7	Oxygen	3,747	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 222,669	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	3,144	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	61,954	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	6,906	20
21	Other Medical Services	9,444	21
22	Laundry	275	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 81,723	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	3,755	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,755	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Transportation Revenue</u>	9,898	28
28a	<u>Miscellaneous Revenue</u>	60	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 9,958	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,140,677	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	537,337	31
32	Health Care	1,029,246	32
33	General Administration	388,339	33
B. Capital Expense			
34	Ownership	181,082	34
C. Ancillary Expense			
35	Special Cost Centers	179,168	35
36	Provider Participation Fee	126,330	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,441,502	40
41	Income before Income Taxes (line 30 minus line 40)**	(300,825)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (300,825)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,380,190	44
45	Private Pay - Net Inpatient Revenue	265,810	45
46	Medicare - Net Inpatient Revenue	155,874	46
47	Other-(specify) <u>Insurance Net Inpatient Revenue</u>	20,698	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 1,822,572	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 Nokomis Rehab & Health Care Center

0050641

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	2,894	2,932	\$ 68,574	\$ 23.39	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,684	3,826	79,354	20.74	3
4	Licensed Practical Nurses	12,046	12,639	225,094	17.81	4
5	CNAs & Orderlies	23,819	24,522	333,767	13.61	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,947	2,011	29,544	14.69	9
10	Activity Assistants					10
11	Social Service Workers	1,981	2,124	37,727	17.76	11
12	Dietician					12
13	Food Service Supervisor	1,297	1,297	16,758	12.92	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,729	11,999	114,839	9.57	15
16	Dishwashers					16
17	Maintenance Workers	2,080	2,080	41,203	19.81	17
18	Housekeepers	7,486	7,817	79,276	10.14	18
19	Laundry	4,888	5,051	51,899	10.27	19
20	Administrator	1,984	2,080	60,667	29.17	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,689	1,753	22,130	12.62	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Page 20A</u>	2,993	3,008	64,473	21.43	33
34	TOTAL (lines 1 - 33)	80,517	83,139	\$ 1,225,305 *	\$ 14.74	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	\$ 1,143	L1, C3	35
36	Medical Director	Monthly	15,000	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,663	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	\$ 20,037		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	2	\$ 125	L10, C3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	2	\$ 125		53

Nokomis Rehab & Health Care Center
 0050641
 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	2,669	2,684	60,523	22.55
Transportation	324	324	3,950	12.19
TOTAL	2,993	3,008	64,473	

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	
Jessica Ashcraft	Administrator	0	\$ 60,667	Workers' Compensation Insurance	\$ 24,318	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance	16,114	Advertising: Employee Recruitment		
				FICA Taxes	84,278	Health Care Worker Background Check		
				Employee Health Insurance	142	(Indicate # of checks performed <u>54</u>)	388	
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	983	
				Employee Relations	640	Miscellaneous Dues & Subscriptions	95	
				Home Office Allocation	14,205	Home Office Allocation	2,445	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 60,667	TOTAL (agree to Schedule V, line 22, col.8)		\$ 5,901		
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			\$ 178,800				Out-of-State Travel	\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 178,800				In-State Travel	
C. Professional Services				TOTAL			Seminar Expense	
Vendor/Payee	Type		Amount				Home Office Allocation	
Consolidated Communications	Computer Services		\$ 1,642				2	
Ability Network	Computer Services		1,073				Entertainment Expense	
New Wave Communications	Computer Services		80				()	
E.L Pruitt	Legal Services		8,244				TOTAL (agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 11,039				\$ 2	

* Attach copy of IMRF notifications

**See instructions.

Nokomis Rehab & Health Care Center

0050641

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)		11,039

Home Office Allocation

Duane Morris	Legal	1364
Sedgwick CMS	Legal	121
SB2	Legal	337
Miscellaneous	Legal	100
Christoper P. Ryan	Legal	107
Saul Ewing Arnstein & Lehr	Legal	477
Healthcare Resources International	Legal	72
Winston & Strawn	Legal	1149
Lexis Nexis	Legal	5
Pretzel & Stouffer	Legal	17
Baker Tilly Virchow Krause	Legal	487
Wells Fargo	Legal	307
CliftonLarsonAllen	Accounting	698
Ginoli & Co.	Accounting	247
Duane Morris	Accounting	41
Getzler Henrich & Associates	Accounting	536
Kemper Consulting	Accounting	41
Baker Tilly Virchow Krause	Accounting	282
Ginoli & Co.	Accounting	1083
Wells Fargo	Accounting	1030
Miscellaneous	Computer Services	75
Change Healthcare	Computer Services	2
TR Professional	Computer Services	7
Matrix Care	Computer Services	783
Ability Network	Computer Services	1240
Stratus Networks	Computer Services	303
Kemper Technology	Computer Services	348
AT&T	Computer Services	4
Ungerboeck Software	Computer Services	251
CIAN	Computer Services	109
Comcast	Computer Services	27
CCH	Computer Services	10
Charter Communications	Computer Services	18
Allscripts	Computer Services	352
ATS	Computer Services	164
Citrix Systems	Computer Services	57
Optimizer	Other Prof Fees	32
Sedgwick CLMS	Other Prof Fees	110
David Budde	Other Prof Fees	31
Sargent Consulting	Other Prof Fees	87
Alix Partners	Other Prof Fees	329
Getzler Henrich & Associates	Other Prof Fees	45
Sargent Consulting	Other Prof Fees	883

Total (agree to Schedule V, line 19, column 8)	<u><u>24,807</u></u>
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Nokomis Rehab & Health Care Center

0050641

Period Beginning

1/1/2018

Period End

12/31/2018

Schedule 21B

XIX. SUPPORT SCHEDULE

Legal Fees

Home Office Allocation-PHN & PHCM

Duane Morris	Legal	1364
Sedgwick CMS	Legal	121
SB2	Legal	337
Miscellaneous	Legal	100
Christoper P. Ryan	Legal	107
Saul Ewing Arnstein & Lehr	Legal	477
Healthcare Resources International	Legal	72
Winston & Strawn	Legal	1149
Lexis Nexis	Legal	5
Pretzel & Stouffer	Legal	17
Baker Tilly Virchow Krause	Legal	487
Wells Fargo	Legal	307

Direct Facility Invoices

E.L Pruitt	1/17/2018	4,122
E.L Pruitt	3/14/2018	4,122
Less Settlement		(8,244)

Total Legal Fees (agree to Schedule V, line 19, column 8)

4,543

**Nokomis Rehab & Health Care Center
0050641**

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

Schedule 21C

25. Administrative and Staff Transportation

Gas	\$	4,027
Auto Repairs		4,053
Travel-Mileage		795
Home Office Allocation		<u>2,509</u>
		<u><u>11,384</u></u>

Facility Name & ID Number Nokomis Rehab & Health Care Center# 0050641Report Period Beginning: 1/1/2018Ending: 12/31/2018**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IHCA-
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 7,975 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. \$ 126,330
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. \$ 2,562
- (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. \$ 9,898
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. Yes
Attach invoices and a summary of services for all architect and appraisal fees