		FOR BHF USE			

LL1

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

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.

I. IDPH License ID Number: 0050849

Facility Name: Roseville Rehabilitation & Health Care

Address: 145 S. Chamberlain Street (Number) Roseville (City) 61473 (Zip Code)

County: Warren

Telephone Number: (309) 426-2134 **Fax #** (309) 426-2445

HFS ID Number:

Date of Initial License for Current Owners: 4/1/2010

Type of Ownership:

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

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 # ( )

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

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

STATE OF ILLINOIS

Facility Name & ID Number Roseville Rehabilitation & Health Care # 0050849 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	99	Skilled (SNF)	99	36,135	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	99	TOTALS	99	36,135	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	13,496	4,596	1,041	19,133	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,496	4,596	1,041	19,133	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 52.95%

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 4/1/2010

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 4/1/2010 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 99 and days of care provided 901

Medicare Intermediary Palmetto

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 Roseville Rehabilitation & Health Care # 0050849 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	145,428	10,120		155,548		155,548	4,647	160,195			1
2	Food Purchase		126,328		126,328		126,328	(5,376)	120,952			2
3	Housekeeping	109,560	14,411		123,971		123,971	74	124,045			3
4	Laundry	39,340	10,058		49,398		49,398		49,398			4
5	Heat and Other Utilities			81,256	81,256		81,256	237	81,493			5
6	Maintenance	44,403	8,333	14,187	66,923		66,923	453	67,376			6
7	Other (specify):* Home Office Ben. Allocation											7
8	**TOTAL General Services**	338,731	169,250	95,443	603,424		603,424	35	603,459			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	877,824	69,282	70,042	1,017,148		1,017,148	2,867	1,020,015			10
10a	Therapy			193,673	193,673		193,673		193,673			10a
11	Activities	58,745	268	299	59,312		59,312	(15,406)	43,906			11
12	Social Services	19,905			19,905		19,905		19,905			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Office Ben. Allocation											15
16	**TOTAL Health Care and Programs**	956,474	69,550	276,014	1,302,038		1,302,038	(12,539)	1,289,499			16
	C. General Administration											
17	Administrative			240,500	240,500		240,500	(186,116)	54,384			17
18	Directors Fees											18
19	Professional Services			17,396	17,396		17,396	14,065	31,461			19
20	Dues, Fees, Subscriptions & Promotions			2,088	2,088		2,088	3,447	5,535			20
21	Clerical & General Office Expenses	30,949	3,023	6,705	40,677		40,677	49,409	90,086			21
22	Employee Benefits & Payroll Taxes			139,296	139,296		139,296	20,026	159,322			22
23	Inservice Training & Education							117	117			23
24	Travel and Seminar							2	2			24
25	Other Admin. Staff Transportation			15,007	15,007		15,007	3,537	18,544			25
26	Insurance-Prop.Liab.Malpractice			2,161	2,161		2,161	43,616	45,777			26
27	Other (specify):* Home Office Ben. Allocation											27
28	**TOTAL General Administration**	30,949	3,023	423,153	457,125		457,125	(51,897)	405,228			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,326,154	241,823	794,610	2,362,587		2,362,587	(64,401)	2,298,186			29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			14,515	14,515		14,515	198,267	212,782			30
31	Amortization of Pre-Op. & Org.							1,095	1,095			31
32	Interest			369	369		369	109,503	109,872			32
33	Real Estate Taxes							116,892	116,892			33
34	Rent-Facility & Grounds			573,946	573,946		573,946	(573,946)				34
35	Rent-Equipment & Vehicles			27,426	27,426		27,426	1,022	28,448			35
36	Other (specify):*											36
37	**TOTAL Ownership**			616,256	616,256		616,256	(147,167)	469,089			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		30,814		30,814		30,814		30,814			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			163,862	163,862		163,862		163,862			42
43	Other (specify):* Miscellaneous	31,680	1,098	51,120	83,898		83,898	(83,898)				43
44	**TOTAL Special Cost Centers**	31,680	31,912	214,982	278,574		278,574	(83,898)	194,676			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,357,834	273,735	1,625,848	3,257,417		3,257,417	(295,466)	2,961,951			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 Roseville Rehabilitation & Health Care # 0050849 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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(5,420)	2		4
5	Telephone, TV & Radio in Resident Rooms	(10,781)	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	57,336	30		9
10	Interest and Other Investment Income	(1,244)	31		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(449)	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	(37,297)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,080)	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	(55,201)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (54,136)		$	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)	(241,330)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (241,330)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (295,466)		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

Roseville Rehabilitation & Health Care

ID# 0050849

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs-Part A	$ (1,755)	43	1
2	X-Rays-Part A	(2,025)	43	2
3	Resident Flowers	(132)	43	3
4	Offset Miscellaneous Office Supplies Revenue	(55)	21	4
5	Offset Transportation Revenue	(15,406)	11	5
6	Offset Miscellaneous Nursing Supplies Revenue	(349)	10	6
7	Special Events	464	43	7
8	Disallowed Equipment Rental Revenue	(3,734)	6	8
9	Disallowed Marketing Expense	(31,680)	43	9
10	Pet Expense	(529)	43	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**	(55,201)		49

Facility Name & ID Number Roseville Rehabilitation & Health Care # 0050849 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		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%	$ 4,647	$ 4,647	1
2	V	2	Food		Petersen Health Care Management, Inc.	100.00%	44	44	2
3	V	3	Housekeeping		Petersen Health Care Management, Inc.	100.00%	74	74	3
4	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	237	237	4
5	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	1,822	1,822	5
6	V	7	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		6
7	V	9	Medical Director		Petersen Health Care Management, Inc.	100.00%	0		7
8	V	10	Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	3,216	3,216	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	240,500	Petersen Health Care Management, Inc.	100.00%	54,384	(186,116)	11
12	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	14,065	14,065	12
13	V								13
14	Total			$ 240,500			$ 78,489	$ * (162,011)	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. [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%	$ 3,447	$ 3,447	15
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	47,681	47,681	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	20,026	20,026	17
18	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	117	117	18
19	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	2	2	19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	3,537	3,537	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	887	887	21
22	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	11,277	11,277	22
23	V	31	Amortization		Petersen Health Care Management, Inc.	100.00%	102	102	23
24	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	2,965	2,965	24
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	351	351	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	1,022	1,022	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			$			$ 91,414	$ * 91,414	39

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

Facility Name & ID Number Roseville Rehabilitation & Health Care # 0050849 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	$	Petersen Health Care-Roseville LLC	100.00%	$ 2,365	$ 2,365	15
16	V	21	Equipment	$	Petersen Health Care-Roseville LLC	100.00%	1,783	1,783	16
17	V	26	Insurance-Property		Petersen Health Care-Roseville LLC	100.00%	5,920	5,920	17
18	V	26	Liability Insurance		Petersen Health Care-Roseville LLC	100.00%	22,397	22,397	18
19	V	26	Mortgage Insurance		Petersen Health Care-Roseville LLC	100.00%	14,412	14,412	19
20	V	30	Depreciation		Petersen Health Care-Roseville LLC	100.00%	129,654	129,654	20
21	V	31	Amortization		Petersen Health Care-Roseville LLC	100.00%	993	993	21
22	V	32	Interest	322	Petersen Health Care-Roseville LLC	100.00%	108,104	107,782	22
23	V	33	Real Estate Taxes		Petersen Health Care-Roseville LLC	100.00%	116,541	116,541	23
24	V	34	Rent-Facility & Grounds	573,946	Petersen Health Care-Roseville LLC	100.00%		(573,946)	24
25	V	43	Service Charges		Petersen Health Care-Roseville LLC	100.00%	1,366	1,366	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			$ 574,268			$ 403,535	$ * (170,733)	39

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

Facility Name & ID Number Roseville Rehabilitation & Health Care # 0050849 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: Roseville Rehabilitation & Health Care # 0050849 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 Roseville Rehabilitation & Health Care # 0050849 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 Roseville Rehabilitation & Health Care # 0050849 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 [ ]

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

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

	1 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	19,133	$ 4,647	1
2	2	Food	Resident Days	1,411,762	75	3,216	0	19,133	44	2
3	3	Housekeeping	Resident Days	1,411,762	75	5,441	2,652	19,133	74	3
4	5	Utilities	Resident Days	1,411,762	75	17,524	0	19,133	237	4
5	6	Maintenance	Resident Days	1,411,762	75	134,460	148,272	19,133	1,822	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,411,762	75	0	0	19,133	0	6
7	9	Medical Director	Resident Days	1,411,762	75	0	0	19,133	0	7
8	10	Nursing and Medical Records	Resident Days	1,411,762	75	237,275	1,454,984	19,133	3,216	8
9	10A	Therapy	Resident Days	1,411,762	75	0	0	19,133	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,411,762	75	0	0	19,133	0	10
11	17	Administrative	Resident Days	1,411,762	75	4,940,583	5,658,897	19,133	54,384	11
12	19	Professional Services	Resident Days	1,411,762	75	1,037,806	0	19,133	14,065	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,411,762	75	254,355	0	19,133	3,447	13
14	21	Clerical and General Office	Resident Days	1,411,762	75	3,518,216	3,764,024	19,133	47,681	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,411,762	75	1,477,639	0	19,133	20,026	15
16	23	Inservice Training & Education	Resident Days	1,411,762	75	8,601	0	19,133	117	16
17	24	Travel and Seminar	Resident Days	1,411,762	75	174	0	19,133	2	17
18	25	Other Admin. Staff Transport.	Resident Days	1,411,762	75	261,018	0	19,133	3,537	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,411,762	75	65,437	0	19,133	887	19
20	30	Depreciation	Resident Days	1,411,762	75	832,087	0	19,133	11,277	20
21	31	Amortization	Resident Days	1,411,762	75	7,528	0	19,133	102	21
22	32	Interest	Resident Days	1,411,762	75	218,814	0	19,133	2,965	22
23	33	Real Estate Taxes	Resident Days	1,411,762	75	25,901	0	19,133	351	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,411,762	75	75,380	0	19,133	1,022	24
25	TOTALS					$ 13,464,326	$ 11,422,040		$ 169,903	25

Facility Name & ID Number Roseville Rehabilitation & Health Care # 0050849 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	Berkadia		X	Mortgage	$44,073.00	4/1/10	$ 3,998,669	$ 2,806,871	3/31/39	0.0614	$ 108,104	1
2	Ford Credit		X	Vehicle	$752.57	3/25/14	38,605	2,101	3/24/19	0.0624	369	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$44,825.57		$ 4,037,274	$ 2,808,972			$ 108,473	9
	B. Non-Facility Related*											
10								Interest Income Offset			(1,566)	10
11								Home Office Allocation-PHCM			2,965	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 1,399	14
15	TOTALS (line 9+line14)						$ 4,037,274	$ 2,808,972			$ 109,872	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 14,412 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 Roseville Rehabilitation & Health Care # 0050849 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.

Description		Amount	Line
1. Real Estate Tax accrual used on 2017 report.	$	123,492	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.)	$	118,245	2
3. Under or (over) accrual (line 2 minus line 1).	$	(5,247)	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)	$	121,788	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** 351 **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.	$	116,892	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Amount	Line
2013	112,420	8
2014	111,975	9
2015	122,043	10
2016	119,891	11
2017	118,245	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 Roseville Rehabilitation & Health Care COUNTY Warren

FACILITY IDPH LICENSE NUMBER 0050849

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)
	Tax Index Number	**Property Description**	**Total Tax**	**Tax Applicable to Nursing Home**
1.	07-050-089-10	Land	$ 512.06	$ 512.06
2.	07-050-090-00	Nursing Facility	$ 117,676.30	$ 117,676.30
3.	07-050-107-00	Land	$ 57.10	$ 57.10
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 118,245.46	$ 118,245.46

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: 29,817 B. General Construction Type: Exterior Brick Frame Block 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: 21,596
2. Number of Years Over Which it is Being Amortized: 21
3. Current Period Amortization: 1,095
4. Dates Incurred: 2013

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		2010	$ 400,000	1
2					2
3	TOTALS			$ 400,000	3

Facility Name & ID Number Roseville Rehabilitation & Health Care # 0050849 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	99		2010		$ 2,998,669	$	25	$ 119,947	$ 119,947	$ 899,602	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Water Heater			2013	5,776		7	822	822	3,699	9
10	Carpeting for Activity Room and Main Hallway			2013	10,088		15	672	672	3,024	10
11	Water Heater			2014	3,228		7	461	461	1,690	11
12	Shower Room Installation			2016	17,484		15	1,166	1,166	2,915	12
13	Boiler			2017	18,608		15	1,240	1,240	1,860	13
14	Removal of Trees			2017	2,650		7	378	378	567	14
15	Water Line Repair			2018	28,298		7	2,021	2,021	2,021	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	Building Booked					119,947			(119,947)		31
32	Building Improvement Booked					8,919			(8,919)		32
33											33
34	2018-Home Office Allocation-Building Improvements				8,999			216	216		34
35	2018-Home Office Allocation-Land Improvements				903			57	57		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 Roseville Rehabilitation & Health Care # 0050849 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,094,703	$ 128,866		$ 126,980	$ (1,886)	$ 915,378	70

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

Facility Name & ID Number Roseville Rehabilitation & Health Care # 0050849 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	$ 649,227	$ 7,033	$ 66,528	$ 59,495	5-10 yrs.	$ 465,761	71
72	Current Year Purchases					7 yrs.		72
73	Fully Depreciated Assets							73
74	Home Office Allocation			11,004	11,004			74
75	TOTALS	$ 649,227	$ 7,033	$ 77,532	$ 70,499		$ 465,761	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	Van	2012	$ 38,000	$	$	$		$ 38,000	76
77	Facility	Ford E250	2014	41,349	8,270	8,270		5 yrs.	37,215	77
78										78
79										79
80	TOTALS			$ 79,349	$ 8,270	$ 8,270	$		$ 75,215	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)	$ 4,223,279	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 144,169	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 212,782	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 68,613	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,456,354	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87	N/A				87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93	N/A		93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

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

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

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

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

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO
16. Rental Amount for movable equipment: $ 28,448 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>

Roseville Rehabilitation & Health Care
0050849
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	$ 24,293
Copier	3,133
Home Office Allocation	1,022
	28,448

Facility Name & ID Number: Roseville Rehabilitation & Health Care # 0050849 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		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	$	5,333	$ 80,001	$	5,333	$ 80,001	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		566	8,487		566	8,487	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		7,012	105,185		7,012	105,185	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				30,814		30,814	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			$	12,911	$ 193,673	$ 30,814	12,911	$ 224,487	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 Roseville Rehabilitation & Health Care # 0050849 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*				1 Operating	2 After Consolidation*	
	A. Current Assets					**C. Current Liabilities**			
1	Cash on Hand and in Banks	$ 85,585	$ 85,785	1	26	Accounts Payable	$ 584,899	$ 608,644	26
2	Cash-Patient Deposits			2	27	Officer's Accounts Payable			27
	Accounts & Short-Term Notes Receivable-				28	Accounts Payable-Patient Deposits			28
3	Patients (less allowance 74,206)	1,160,142	1,160,142	3	29	Short-Term Notes Payable			29
4	Supply Inventory (priced at Cost)			4	30	Accrued Salaries Payable	44,979	44,979	30
5	Short-Term Investments			5		Accrued Taxes Payable			
6	Prepaid Insurance	44,639	48,202	6	31	(excluding real estate taxes)	898	898	31
7	Other Prepaid Expenses			7	32	Accrued Real Estate Taxes(Sch.IX-B)		121,788	32
8	Accounts Receivable (owners or related parties)			8	33	Accrued Interest Payable		8,771	33
9	Other(specify):			9	34	Deferred Compensation	2,032	2,032	34
	TOTAL Current Assets				35	Federal and State Income Taxes			35
10	**(sum of lines 1 thru 9)**	$ 1,290,366	$ 1,294,129	10		**Other Current Liabilities(specify):**			
	B. Long-Term Assets				36	Payroll Withholdings	352,266	352,266	36
11	Long-Term Notes Receivable			11	37	Accrued Management Fees	2,088,294	2,088,294	37
12	Long-Term Investments			12		**TOTAL Current Liabilities**			
13	Land		400,000	13	38	**(sum of lines 26 thru 37)**	$ 3,073,368	$ 3,227,672	38
14	Buildings, at Historical Cost		3,007,668	14		**D. Long-Term Liabilities**			
15	Leasehold Improvements, at Historical Cost	21,742	87,035	15	39	Long-Term Notes Payable	2,101	2,101	39
16	Equipment, at Historical Cost	106,703	728,576	16	40	Mortgage Payable		2,806,871	40
17	Accumulated Depreciation (book methods)	(103,328)	(1,456,354)	17	41	Bonds Payable			41
18	Deferred Charges			18	42	Deferred Compensation			42
19	Organization & Pre-Operating Costs		21,596	19		**Other Long-Term Liabilities(specify):**			
	Accumulated Amortization -				43				43
20	Organization & Pre-Operating Costs		(8,689)	20	44				44
21	Restricted Funds		989,200	21		**TOTAL Long-Term Liabilities**			
22	Other Long-Term Assets (specify):			22	45	**(sum of lines 39 thru 44)**	$ 2,101	$ 2,808,972	45
23	Other(specify):			23		**TOTAL LIABILITIES**			
	TOTAL Long-Term Assets				46	**(sum of lines 38 and 45)**	$ 3,075,469	$ 6,036,644	46
24	**(sum of lines 11 thru 23)**	$ 25,117	$ 3,769,032	24					
					47	**TOTAL EQUITY(page 18, line 24)**	$ (1,759,986)	$ (973,483)	47
	TOTAL ASSETS					**TOTAL LIABILITIES AND EQUITY**			
25	**(sum of lines 10 and 24)**	$ 1,315,483	$ 5,063,161	25	48	**(sum of lines 46 and 47)**	$ 1,315,483	$ 5,063,161	48

*(See instructions.)

Facility Name & ID Number Roseville Rehabilitation & Health Care # 0050849 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,587,484)	1
2	Restatements (describe):		2
3	Rounding	(4)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,587,488)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(172,498)	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)**	$ (172,498)	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)**	$ (1,759,986)	24 *

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

Facility Name & ID Number Roseville Rehabilitation & Health Care # 0050849 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	$ 2,786,064	1
2	Discounts and Allowances for all Levels	(186,895)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,599,169	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	395,425	6
7	Oxygen	2,548	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 397,973	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	292	13
14	Non-Patient Meals	5,420	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	39,884	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	7,009	20
21	Other Medical Services	14,270	21
22	Laundry	114	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 66,989	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,244	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,244	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Transportation Revenue	15,406	28
28a	Miscellaneous Revenue	4,138	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 19,544	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,084,919	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	603,424	31
32	Health Care	1,302,038	32
33	General Administration	457,125	33
	B. Capital Expense		
34	Ownership	616,256	34
	C. Ancillary Expense		
35	Special Cost Centers	114,712	35
36	Provider Participation Fee	163,862	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,257,417	40
41	**Income before Income Taxes (line 30 minus line 40)****	(172,498)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (172,498)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,708,319	44
45	Private Pay - Net Inpatient Revenue	737,175	45
46	Medicare - Net Inpatient Revenue	134,777	46
47	Other-(specify) Insurance Net Inpatient Revenue	18,898	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,599,169	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 Roseville Rehabilitation & Health Care # 0050849 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,401	1,638	$ 53,993	$ 32.96	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,965	6,145	154,115	25.08	3
4	Licensed Practical Nurses	11,191	11,507	243,835	21.19	4
5	CNAs & Orderlies	27,350	28,231	361,631	12.81	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,040	1,040	17,281	16.62	9
10	Activity Assistants	1,535	1,535	14,484	9.44	10
11	Social Service Workers	1,755	1,987	19,905	10.02	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	29,943	14.40	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,787	12,211	115,485	9.46	15
16	Dishwashers					16
17	Maintenance Workers	1,616	1,767	44,403	25.13	17
18	Housekeepers	9,072	9,559	109,560	11.46	18
19	Laundry	2,080	2,080	39,340	18.91	19
20	Administrator	1,703	1,703	54,384	31.93	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,918	2,101	30,949	14.73	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	540	540	11,367	21.05	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	122	122	1,836	15.05	31
32	Other Health Care(specify)					32
33	Other(specify) Page 20A	6,050	6,163	109,707	17.80	33
34	TOTAL (lines 1 - 33)	87,205	90,409	$ 1,412,218 *	$ 15.62	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	5,123	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	6	376	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)	6	$ 17,499		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	540	$ 23,534	L10, C3	50
51	Licensed Practical Nurses	24	700	L10, C3	51
52	Certified Nurse Assistants/Aides	1,183	39,701	L10, C3	52
53	TOTAL (lines 50 - 52)	1,747	$ 63,935		53

Roseville Rehabilitation & Health Care
0050849
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	2,080	2,080	51,047	24.54
Transportation	1,890	2,003	26,980	13.47
Marketing	2,080	2,080	31,680	15.23
TOTAL	6,050	6,163	109,707	

Facility Name & ID Number: Roseville Rehabilitation & Health Care # 0050849 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Janet Holmberg	Administrator	0	$ 54,384
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 54,384

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 240,500
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 240,500

C. Professional Services

Vendor/Payee	Type	Amount
Frontier	Computer Services	$ 1,117
Ability Network	Computer Services	1,094
Sorling Northrup	Legal Fees	8,000
Mediacom	Computer Services	1,414
Peoria County Recorder	Legal Filing Fees	51
Ginoli and Company	Accounting Fees	5,720
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 17,396

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 26,168
Unemployment Compensation Insurance	8,809
FICA Taxes	102,534
Employee Health Insurance	190
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	1,595
Home Office Allocation	20,026
TOTAL (agree to Schedule V, line 22, col.8)	$ 159,322

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	$
Advertising: Employee Recruitment	263
Health Care Worker Background Check	
(Indicate # of checks performed 12)	360
Patient Background Checks	624
Miscellaneous Licenses & Permits	801
Miscellaneous Dues & Subscriptions	40
Home Office Allocation	3,447
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,535

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Home Office Allocation	2
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2

**See instructions.

Roseville Rehabilitation & Health Care
0050849

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)		17,396
Home Office Allocation		
Duane Morris	Legal	1923
Sedgwick CMS	Legal	170
SB2	Legal	475
Miscellaneous	Legal	141
Christoper P. Ryan	Legal	150
Saul Ewing Arnstein & Lehr	Legal	673
Healthcare Resources International	Legal	101
Winston & Strawn	Legal	1620
Lexis Nexis	Legal	7
Pretzel & Stouffer	Legal	24
CliftonLarsonAllen	Accounting	983
Ginoli & Co.	Accounting	349
Duane Morris	Accounting	57
Getzler Henrich & Associates	Accounting	755
Kemper Consulting	Accounting	57
Baker Tilly Virchow Krause	Accounting	398
Miscellaneous	Computer Services	104
Change Healthcare	Computer Services	3
TR Professional	Computer Services	10
Matrix Care	Computer Services	1104
Ability Network	Computer Services	1749
Stratus Networks	Computer Services	428
Kemper Technology	Computer Services	491
AT&T	Computer Services	6
Ungerboeck Software	Computer Services	353
CIAN	Computer Services	154
Comcast	Computer Services	38
CCH	Computer Services	14
Charter Communications	Computer Services	26
Allscripts	Computer Services	497
ATS	Computer Services	231
Citrix Systems	Computer Services	81
Optimizer	Other Prof Fees	45
Sedgwick CLMS	Other Prof Fees	155
David Budde	Other Prof Fees	44
Sargent Consulting	Other Prof Fees	122
Alix Partners	Other Prof Fees	464
Getzler Henrich & Associates	Other Prof Fees	63
Total (agree to Schedule V, line 19, column 8)		31,461

Roseville Rehabilitation & Health Care
0050849

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

Schedule 21B

XIX. SUPPORT SCHEDULE
Legal Fees

Home Office Allocation-PHC & PHCM

Duane Morris	Legal	1923
Sedgwick CMS	Legal	170
SB2	Legal	475
Miscellaneous	Legal	141
Christoper P. Ryan	Legal	150
Saul Ewing Arnstein & Lehr	Legal	673
Healthcare Resources International	Legal	101
Winston & Strawn	Legal	1620
Lexis Nexis	Legal	7
Pretzel & Stouffer	Legal	24

Direct Facility Invoices

Sorling Northrup-Crain Case	8/9/2017	7,934
Sorling Northrup-Crain Case	12/4/2017	17
Sorling Northrup-Crain Case	1/8/2018	33
Sorling Northrup-Crain Case	2/9/2018	17
Peoria County Recorder-Filing Fees	5/18/2018	51

Total Legal Fees (agree to Schedule V, line 19, column 8 13,336

Roseville Rehabilitation & Health Care
0050849
Period Beginning 1/1/2018
Period End 12/31/2018

Schedule 21C

25. Administrative and Staff Transportation

Gas	$	6,912
Auto Repairs		1,047
Travel-Mileage		7,048
Home Office Allocation		3,537
		18,544

Facility Name & ID Number Roseville Rehabilitation & Health Care # 0050849 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. $ **15,089** 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. $ **163,862**
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. $ **5,420**

(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. $ **15,406**

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 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