



Facility Name & ID Number Sullivan Health Care Center

# 0046425 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

**III. STATISTICAL DATA**

**A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds** N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	123	Skilled (SNF)	123	44,895	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	123	TOTALS	123	44,895	7

**B. Census-For the entire report period.**

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	17,530	3,505	2,734	23,769	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,530	3,505	2,734	23,769	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.)** 52.94%

**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 9/3/2003

**J. Was the facility purchased or leased after January 1, 1978?**  
YES  Date 9/3/2003 NO

**K. Was the facility certified for Medicare during the reporting year?**  
YES  NO  If YES, enter number of beds certified 123 and days of care provided 2,464

Medicare Intermediary National Government Services

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

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

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

Facility Name & ID Number Sullivan Health Care Center # 0046425 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
	<b>A. General Services</b>										
1	Dietary	169,703	21,301	546	191,550		191,550	5,773	197,323		1
2	Food Purchase		151,368		151,368		151,368	(1,326)	150,042		2
3	Housekeeping	109,844	27,279		137,123		137,123	92	137,215		3
4	Laundry	144	10,484	17,160	27,788		27,788		27,788		4
5	Heat and Other Utilities			189,547	189,547		189,547	295	189,842		5
6	Maintenance	54,489	10,882	12,696	78,067		78,067	2,264	80,331		6
7	Other (specify):* <u>Home Office Ben. Allocation</u>										7
8	<b>TOTAL General Services</b>	334,180	221,314	219,949	775,443		775,443	7,098	782,541		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	1,212,308	167,700	7,549	1,387,557		1,387,557	5,737	1,393,294		10
10a	Therapy			330,856	330,856		330,856		330,856		10a
11	Activities	49,333		22,834	72,167		72,167	(6,349)	65,818		11
12	Social Services	39,745	14		39,759		39,759		39,759		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Office Ben. Allocation</u>										15
16	<b>TOTAL Health Care and Programs</b>	1,301,386	167,714	373,239	1,842,339		1,842,339	(612)	1,841,727		16
	<b>C. General Administration</b>										
17	Administrative			283,200	283,200		283,200	(219,575)	63,625		17
18	Directors Fees										18
19	Professional Services			3,102	3,102		3,102	64,150	67,252		19
20	Dues, Fees, Subscriptions & Promotions			3,328	3,328		3,328	3,964	7,292		20
21	Clerical & General Office Expenses	33,693	3,364	15,232	52,289		52,289	59,175	111,464		21
22	Employee Benefits & Payroll Taxes			177,700	177,700		177,700	25,955	203,655		22
23	Inservice Training & Education			(968)	(968)		(968)	145	(823)		23
24	Travel and Seminar							3	3		24
25	Other Admin. Staff Transportation			10,245	10,245		10,245	4,395	14,640		25
26	Insurance-Prop.Liab.Malpractice			36,497	36,497		36,497	1,102	37,599		26
27	Other (specify):* <u>Home Office Ben. Allocation</u>										27
28	<b>TOTAL General Administration</b>	33,693	3,364	528,336	565,393		565,393	(60,686)	504,707		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,669,259	392,392	1,121,524	3,183,175		3,183,175	(54,200)	3,128,975		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 Sullivan Health Care Center

#0046425

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	
	<b>D. Ownership</b>											
30	Depreciation			60,458	60,458		60,458	14,944	75,402			30
31	Amortization of Pre-Op. & Org.							127	127			31
32	Interest			83,343	83,343		83,343	42,775	126,118			32
33	Real Estate Taxes			44,961	44,961		44,961	436	45,397			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			49,847	49,847		49,847	1,269	51,116			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			238,609	238,609		238,609	59,551	298,160			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		74,009		74,009		74,009		74,009			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			195,270	195,270		195,270		195,270			42
43	Other (specify):* <b>Miscellaneous</b>		1,173	78,508	79,681		79,681	(79,681)				43
44	<b>TOTAL Special Cost Centers</b>		75,182	273,778	348,960		348,960	(79,681)	269,279			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,669,259	467,574	1,633,911	3,770,744		3,770,744	(74,330)	3,696,414			45

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

**VI. ADJUSTMENT DETAIL**

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,380)	2		4
5	Telephone, TV & Radio in Resident Rooms	(9,526)	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	138	30		9
10	Interest and Other Investment Income	(191)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(90)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(43,071)	43		18
19	Entertainment				19
20	Contributions	(200)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(12,000)	43		24
25	Fund Raising, Advertising and Promotional	(855)	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	(21,133)	Various		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (88,308)		\$	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	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)	13,978	Various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 13,978		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (74,330)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

Sullivan Health Care Center

ID# 0046425

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (8,109)	43	1
2	X-Rays-Part A	(4,839)	43	2
3	Resident Flowers	(529)	43	3
4	Offset Miscellaneous Transportation Revenue	(6,349)	11	4
5	Offset Miscellaneous Office Supplies Revenue	(59)	21	5
6	Pet Expense	(511)	43	6
7	Offset Chamber of Commerce Dues	(318)	20	7
8	Offset Miscellaneous Nursing Supplies Revenue	(468)	10	8
9	Special Events	49	43	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(21,133)		49

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	1 Dietary	\$	Petersen Health Care Management, Inc.	100.00%	\$ 5,773	\$ 5,773	1
2	V	2 Food		Petersen Health Care Management, Inc.	100.00%	54	54	2
3	V	3 Housekeeping		Petersen Health Care Management, Inc.	100.00%	92	92	3
4	V	5 Utilities		Petersen Health Care Management, Inc.	100.00%	295	295	4
5	V	6 Maintenance		Petersen Health Care Management, Inc.	100.00%	2,264	2,264	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%	3,995	3,995	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	205,200	Petersen Health Care Management, Inc.	100.00%	63,625	(141,575)	11
12	V	19 Professional Services		Petersen Health Care Management, Inc.	100.00%	17,473	17,473	12
13	V							13
14	Total		\$ 205,200			\$ 93,571	\$ * (111,629)	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 &amp; Promotions</u>	\$	<u>Petersen Health Care Management, Inc.</u>	100.00%	\$ 4,282	\$	4,282	15
16	V	21 <u>Clerical and General Office</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	59,234		59,234	16
17	V	22 <u>Employee Benefits and Payroll Taxes</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	24,878		24,878	17
18	V	23 <u>Inservice Training &amp; Education</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	145		145	18
19	V	24 <u>Travel and Seminar</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	3		3	19
20	V	25 <u>Other Admin. Staff Transport.</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	4,395		4,395	20
21	V	26 <u>Insurance-Prop./Liab./Malprac.</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	1,102		1,102	21
22	V	30 <u>Depreciation</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	14,009		14,009	22
23	V	31 <u>Amortization</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	127		127	23
24	V	32 <u>Interest</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	3,684		3,684	24
25	V	33 <u>Real Estate Taxes</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	436		436	25
26	V	35 <u>Rent-Equipment &amp; Vehicles</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	1,269		1,269	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	<b>Total</b>		\$			\$ 113,564	\$ *	113,564	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 Care II, LLC	100.00%	\$ 0	\$	15
16	V	2 Food		Petersen Health Care II, LLC	100.00%	0		16
17	V	3 Housekeeping		Petersen Health Care II, LLC	100.00%	0		17
18	V	4 Laundry		Petersen Health Care II, LLC	100.00%	0		18
19	V	5 Utilities		Petersen Health Care II, LLC	100.00%	0		19
20	V	6 Maintenance		Petersen Health Care II, LLC	100.00%	0		20
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Care II, LLC	100.00%	0		21
22	V	10 Nursing and Medical Records		Petersen Health Care II, LLC	100.00%	2,210	2,210	22
23	V	15 Mgmt. Allocation of Benefits		Petersen Health Care II, LLC	100.00%	0		23
24	V	17 Administrative	78,000	Petersen Health Care II, LLC	100.00%	0	(78,000)	24
25	V	19 Professional Services		Petersen Health Care II, LLC	100.00%	46,677	46,677	25
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Care II, LLC	100.00%	0		26
27	V	21 Clerical and General Office		Petersen Health Care II, LLC	100.00%	0		27
28	V	22 Employee Benefits & Payroll		Petersen Health Care II, LLC	100.00%	1,077	1,077	28
29	V	23 Inservice Training & Education		Petersen Health Care II, LLC	100.00%	0		29
30	V	24 Travel and Seminar		Petersen Health Care II, LLC	100.00%	0		30
31	V	25 Other Admin. Staff Transport.		Petersen Health Care II, LLC	100.00%	0		31
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care II, LLC	100.00%	0		32
33	V	30 Depreciation		Petersen Health Care II, LLC	100.00%	797	797	33
34	V	31 Amortization		Petersen Health Care II, LLC	100.00%	0		34
35	V	32 Interest		Petersen Health Care II, LLC	100.00%	39,282	39,282	35
36	V	33 Real Estate Taxes		Petersen Health Care II, LLC	100.00%	0		36
37	V	34 Rent-Facility and Grounds		Petersen Health Care II, LLC	100.00%	0		37
38	V	35 Rent-Equipment & Vehicles		Petersen Health Care II, LLC	100.00%	0		38
39	Total		\$ 78,000			\$ 90,043	\$ * 12,043	39

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

Facility Name &amp; ID Number

Sullivan Health Care Center

# 0046425

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 &amp; ID Number

Sullivan Health Care Center

# 0046425

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 &amp; ID Number

Bloomington Rehabilitation &amp; 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 Sullivan Health Care Center # 0046425 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 Sullivan Health Care Center

# 0046425

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	23,769	\$ 5,773	1
2	2	Food	Resident Days	1,411,762	75	3,216	0	23,769	54	2
3	3	Housekeeping	Resident Days	1,411,762	75	5,441	2,652	23,769	92	3
4	5	Utilities	Resident Days	1,411,762	75	17,524	0	23,769	295	4
5	6	Maintenance	Resident Days	1,411,762	75	134,460	148,272	23,769	2,264	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,411,762	75	0	0	23,769	0	6
7	9	Medical Director	Resident Days	1,411,762	75	0	0	23,769	0	7
8	10	Nursing and Medical Records	Resident Days	1,411,762	75	237,275	1,454,984	23,769	3,995	8
9	10A	Therapy	Resident Days	1,411,762	75	0	0	23,769	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,411,762	75	0	0	23,769	0	10
11	17	Administrative	Resident Days	1,411,762	75	4,940,583	5,658,897	23,769	63,625	11
12	19	Professional Services	Resident Days	1,411,762	75	1,037,806	0	23,769	17,473	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,411,762	75	254,355	0	23,769	4,282	13
14	21	Clerical and General Office	Resident Days	1,411,762	75	3,518,216	3,764,024	23,769	59,234	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,411,762	75	1,477,639	0	23,769	24,878	15
16	23	Inservice Training & Education	Resident Days	1,411,762	75	8,601	0	23,769	145	16
17	24	Travel and Seminar	Resident Days	1,411,762	75	174	0	23,769	3	17
18	25	Other Admin. Staff Transport.	Resident Days	1,411,762	75	261,018	0	23,769	4,395	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,411,762	75	65,437	0	23,769	1,102	19
20	30	Depreciation	Resident Days	1,411,762	75	832,087	0	23,769	14,009	20
21	31	Amortization	Resident Days	1,411,762	75	7,528	0	23,769	127	21
22	32	Interest	Resident Days	1,411,762	75	218,814	0	23,769	3,684	22
23	33	Real Estate Taxes	Resident Days	1,411,762	75	25,901	0	23,769	436	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,411,762	75	75,380	0	23,769	1,269	24
25	TOTALS					\$ 13,464,326	\$ 11,422,040		\$ 207,135	25

Facility Name & ID Number Sullivan Health Care Center

# 0046425

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 II, 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	135,903	5	\$	\$ 23,769	\$	1
2	2	Food	Resident Days	135,903	5		23,769		2
3	3	Housekeeping	Resident Days	135,903	5		23,769		3
4	4	Laundry	Resident Days	135,903	5		23,769		4
5	5	Utilities	Resident Days	135,903	5		23,769		5
6	6	Maintenance	Resident Days	135,903	5		23,769		6
7	7	Mgmt. Allocation of Benefits	Resident Days	135,903	5		23,769		7
8	10	Nursing and Medical Records	Resident Days	135,903	5	12,637	23,769	2,210	8
9	15	Mgmt. Allocation of Benefits	Resident Days	135,903	5		23,769		9
10	17	Administrative	Resident Days	135,903	5		23,769		10
11	19	Professional Services	Resident Days	135,903	5	266,883	23,769	46,677	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	135,903	5		23,769		12
13	21	Clerical and General Office	Resident Days	135,903	5		23,769		13
14	22	Employee Benefits & Payroll	Resident Days	135,903	5	6,156	23,769	1,077	14
15	23	Inservice Training & Education	Resident Days	135,903	5		23,769		15
16	24	Travel and Seminar	Resident Days	135,903	5		23,769		16
17	25	Other Admin. Staff Transport.	Resident Days	135,903	5		23,769		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	135,903	5		23,769		18
19	30	Depreciation	Resident Days	135,903	5	4,559	23,769	797	19
20	31	Amortization	Resident Days	135,903	5		23,769		20
21	32	Interest	Resident Days	135,903	5	224,601	23,769	39,282	21
22	33	Real Estate Taxes	Resident Days	135,903	5		23,769		22
23	34	Rent-Facility and Grounds	Resident Days	135,903	5		23,769		23
24	35	Rent-Equipment & Vehicles	Resident Days	135,903	5		23,769		24
25	TOTALS					\$ 514,836	\$	\$ 90,043	25



Facility Name & ID Number

Sullivan Health Care Center

# 0046425

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			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	Huntington Bank		X	Mortgage	Varies	2/1/17	\$ 1,743,600	\$ 1,288,275	1/31/42	Varies	\$ 83,343	1						
2												2						
3												3						
4												4						
5												5						
<b>Working Capital</b>																		
6												6						
7												7						
8												8						
9	<b>TOTAL Facility Related</b>						\$ 1,743,600	\$ 1,288,275			\$ 83,343	9						
<b>B. Non-Facility Related*</b>																		
10									Interest Income Offset		(191)	10						
11									Home Office Allocation-PHCM		39,282	11						
12									Home Office Allocation-PHC II		3,684	12						
13												13						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ 42,775	14						
15	<b>TOTALS (line 9+line14)</b>						\$ 1,743,600	\$ 1,288,275			\$ 126,118	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 Sullivan Health Care Center COUNTY Moultrie

FACILITY IDPH LICENSE NUMBER 0046425

CONTACT PERSON REGARDING THIS REPORT MIKE KOCHER

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

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

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

(A)	(B)	(C)	(D) <u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to Nursing Home</u>
1. <u>08-08-11-400-004</u>	<u>Long-Term Care Facility</u>	\$ <u>46,937.84</u>	\$ <u>46,937.84</u>
2. <u>08-08-12-300-073</u>	<u>Long-Term Care Facility</u>	\$ <u>375.62</u>	\$ <u>375.62</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ <u><u>47,313.46</u></u>	\$ <u><u>47,313.46</u></u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?        YES        NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the original 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

**PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.**

Facility Name & ID Number Sullivan Health Care Center

# 0046425 Report Period Beginning:

1/1/2018 Ending:

12/31/2018

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 28,000 B. General Construction Type: Exterior Brick & Block Frame Concrete 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: 799,059 2. Number of Years Over Which it is Being Amortized: 20  
3. Current Period Amortization: 127 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>339,095</u>	<u>2003</u>	<u>\$ 100,001</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>339,095</b>		<b>\$ 100,001</b>	<b>3</b>

**XI. OWNERSHIP COSTS (continued)**

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	123		2003	1975	\$ 1,560,545	\$	39	\$ 40,014	\$ 40,014	\$ 613,548	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Carpeting		2004		4,808		25	192	192	2,736	9
10	Fire Alarms		2004		1,524		25	61	61	844	10
11	Doors		2004		3,067		5			3,067	11
12	Smoke Alarms		2004		1,227		7			1,227	12
13	Land Improvements		2006		7,262		15	484	484	6,050	13
14	New Roof		2006		28,308		25	1,132	1,132	14,150	14
15	Kitchen Remodel		2006		22,241		25	890	890	11,125	15
16	Landscaping		2006		2,434		15	162	162	2,025	16
17	Sidewalks		2007		1,785		15	120	120	1,380	17
18	Sprinkler System		2008		14,839		25	594	594	6,237	18
19	Back Flow		2009		5,470		7			5,470	19
20	Water Heater		2009		2,983		5			2,983	20
21	Roof Repairs		2011		2,536		7	183	183	2,536	21
22	Nurses Station		2013		17,449		15	1,164	1,164	6,402	22
23	Tiling of Shower		2014		8,225		15	548	548	2,740	23
24	Water Heater-LA		2014		3,493		7	499	499	2,246	24
25	Roof Repairs		2014		2,800		7	400	400	1,800	25
26	Roof Replacement		2014		6,764		25	271	271	1,220	26
27	Roof Replacement		2014		12,600		25	504	504	2,268	27
28	Fencing		2014		3,395		15	226	226	1,017	28
29	Grease Trap Repair		2014		5,222		7	746	746	3,357	29
30	Water Heater		2014		3,375		7	482	482	2,169	30
31	A/C Unit - Roof Top		2014		8,384		15	559	559	2,516	31
32	Furnace		2016		9,734		15	648	648	1,620	32
33	Window Framing, Gutter Replace, Privacy Fence, Roof Repair		2016		26,314		15	1,754	1,754	4,385	33
34	Roof Replacement		2018		157,173		25	3,143	3,143	3,143	34
35											35
36											36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	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					765		(765)	61
62					40,014		(40,014)	62
63					14,864		(14,864)	63
64								64
65			11,180			268	268	65
66			1,121			71	71	66
67								67
68								68
69								69
70			\$ 1,936,258		\$ 55,643	\$ 55,115	\$ (528)	\$ 708,261 70

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

Facility Name & ID Number Sullivan Health Care Center

# 0046425

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	\$ 60,686	\$ 4,781	\$ 5,718	\$ 937	5-10 yrs.	\$ 40,068	71
72	Current Year Purchases	1,428	34	102	68	7 yrs.	102	72
73	Fully Depreciated Assets	630,533					630,533	73
74	Home Office Allocation			14,467	14,467			74
75	TOTALS	\$ 692,647	\$ 4,815	\$ 20,287	\$ 15,472		\$ 670,703	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	2003 Ford	2003	\$ 31,116	\$		\$		\$ 31,116	76
77										77
78										78
79										79
80	TOTALS			\$ 31,116	\$	\$	\$		\$ 31,116	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,760,022	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 60,458	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 75,402	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 14,944	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,410,080	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	<b>TOTAL</b>				\$			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: \$ 51,116 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	<b>TOTAL</b>		\$	\$	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.



**Sullivan Health Care Center**

**0046425**

**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	\$ 42,779
Dishwasher	701
Copier	6,367
Home Office Allocation	1,269
	<u>51,116</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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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	\$	9,622	\$ 144,324	\$	9,622	\$ 144,324	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		3,008	45,124		3,008	45,124	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		9,366	140,484		9,366	140,484	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				74,009		74,009	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Respiratory Therapy</u>	10A(3)	hrs		62	924		62	924	12
13	Other (specify): _____									13
14	<b>TOTAL</b>			\$	22,058	\$ 330,856	\$ 74,009	22,058	\$ 404,865	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 Sullivan Health Care Center

# 0046425

Report Period Beginning: 1/1/2018

Ending:

12/31/2018

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2018

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 311,944	\$ 311,944	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 110,961 )	1,446,083	1,446,083	3
4	Supply Inventory (priced at Cost )	13,122	13,122	4
5	Short-Term Investments			5
6	Prepaid Insurance	23,839	23,839	6
7	Other Prepaid Expenses	90,790	90,790	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Employee Education Loans</u>	945	945	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,886,723	\$ 1,886,723	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	111,481	100,001	13
14	Buildings, at Historical Cost	1,560,545	1,571,725	14
15	Leasehold Improvements, at Historical Cost	347,634	364,533	15
16	Equipment, at Historical Cost	723,763	723,763	16
17	Accumulated Depreciation (book methods)	(1,410,458)	(1,410,080)	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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,332,965	\$ 1,349,942	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,219,688	\$ 3,236,665	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 1,069,663	\$ 1,069,663	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	81,710	81,710	30
31	Accrued Taxes Payable (excluding real estate taxes)	481,896	481,896	31
32	Accrued Real Estate Taxes(Sch.IX-B)	96,045	96,045	32
33	Accrued Interest Payable	7,228	7,228	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Payroll Withholdings</u>	1,233	1,233	36
37	<u>Accrued Management Fees</u>	21,712	21,712	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,759,487	\$ 1,759,487	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,288,275	1,288,275	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<u>Intercompany Loans</u>			43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 1,288,275	\$ 1,288,275	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 3,047,762	\$ 3,047,762	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 171,926	\$ 188,903	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,219,688	\$ 3,236,665	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(165,769)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(165,769)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>337,695</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>337,695</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>171,926</b>	<b>24</b> *

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

Facility Name &amp; ID Number Sullivan Health Care Center

# 0046425

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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 3,642,148	1
2	Discounts and Allowances for all Levels	(392,977)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,249,171	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	649,208	6
7	Oxygen	2,232	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 651,440	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,380	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	142,875	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	14,136	20
21	Other Medical Services	42,343	21
22	Laundry	27	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 200,761	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	191	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 191	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Transportation Revenue</u>	6,349	28
28a	<u>Miscellaneous Revenue</u>	527	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 6,876	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,108,439	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	775,443	31
32	Health Care	1,842,339	32
33	General Administration	565,393	33
<b>B. Capital Expense</b>			
34	Ownership	238,609	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	153,690	35
36	Provider Participation Fee	195,270	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,770,744	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	337,695	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 337,695	43

<b>III. Net Inpatient Revenue detailed by Payer Source</b>			
44	Medicaid - Net Inpatient Revenue	\$ 2,232,760	44
45	Private Pay - Net Inpatient Revenue	539,942	45
46	Medicare - Net Inpatient Revenue	451,615	46
47	Other-(specify) <u>Insurance Net Inpatient Revenue</u>	24,854	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 3,249,171	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 Sullivan Health Care Center

# 0046425

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	2,638	2,686	\$ 81,951	\$ 30.51	1
2	Assistant Director of Nursing	1,760	1,760	52,549	29.86	2
3	Registered Nurses	5,438	5,623	126,833	22.56	3
4	Licensed Practical Nurses	14,882	15,357	303,426	19.76	4
5	CNAs & Orderlies	43,904	44,632	566,035	12.68	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,907	2,003	30,448	15.20	8
9	Activity Director	1,525	1,738	23,508	13.53	9
10	Activity Assistants	287	287	2,675	9.32	10
11	Social Service Workers	1,882	2,103	39,745	18.90	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	44,006	21.16	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,723	14,313	125,697	8.78	15
16	Dishwashers					16
17	Maintenance Workers	3,064	3,204	54,489	17.01	17
18	Housekeepers	10,159	10,233	109,844	10.73	18
19	Laundry			144		19
20	Administrator	1,993	2,065	63,625	30.81	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,511	1,628	33,693	20.70	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	6	6	120	20.00	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Page 20A</u>	3,313	3,460	74,096	21.42	33
34	TOTAL (lines 1 - 33)	110,072	113,178	\$ 1,732,884 *	\$ 15.31	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	\$ 546	L1, C3	35
36	Medical Director	Monthly	12,000	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,691	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 19,237		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	16	\$ 821	L10, C3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	16	\$ 821		53

**Sullivan Health Care Center**

**0046425**

**Period Beginning 1/1/2018**

**Period End 12/31/2018**

**Schedule 20A**

**XVIII. Staffing and Salary Costs**

	<b># of Hrs. Actually Worked</b>	<b># of Hrs. Paid and Accrued</b>	<b>Reporting Period Total Salaries, Wages</b>	<b>Average Hourly Wage</b>
<b>Care Plan Coordinator</b>	1,918	2,065	50,946	24.67
<b>Transportation</b>	1,395	1,395	23,150	16.59
<b>TOTAL</b>	<u>3,313</u>	<u>3,460</u>	<u>74,096</u>	



**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	
Valerie Tischler	Administrator	0	\$ 7,667	Workers' Compensation Insurance	\$ 31,481	IDPH License Fee	\$	
Valerie Logsdon	Administrator	0	55,958	Unemployment Compensation Insurance	22,393	Advertising: Employee Recruitment		
				FICA Taxes	121,155	Health Care Worker Background Check (Indicate # of checks performed <u>30</u> )	906	
				Employee Health Insurance	795	Patient Background Checks	1,671	
				Employee Meals		Miscellaneous Licenses & Permits	433	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Dues & Subscriptions	318	
				Employee Relations	292	Home Office Allocation	4,282	
				Home Office Allocation	25,955			
				Employee Retirement	1,584			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 63,625	TOTAL (agree to Schedule V, line 22, col.8)		\$ 203,655	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 7,292
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			\$ 283,200				Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 283,200				Seminar Expense	
C. Professional Services							Home Office Allocation	3
Vendor/Payee	Type		Amount				Entertainment Expense (agree to Sch. V, line 24, col. 8)	( )
Allscripts	Data Services		\$ 444				TOTAL	\$ 3
Mediacom	Computer Services		1,585					
Ability Network	Computer Services		1,073					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 3,102	TOTAL		\$		

\* Attach copy of IMRF notifications

\*\*See instructions.

**Sullivan Health Care Center**

**0046425**

**Period Beginning**

**1/1/2018**

**Period End**

**12/31/2018**

**Schedule 21A**

**XIX. SUPPORT SCHEDULE**

**C. Professional Services**

<b>Vendor/Payee</b>	<b>Type</b>	<b>Amount</b>
Total (agree to Schedule V, line 19, column 3)		3,102
<b>Home Office Allocation</b>		
Duane Morris	Legal	2388
Sedgwick CMS	Legal	211
SB2	Legal	590
Miscellaneous	Legal	176
Christoper P. Ryan	Legal	187
Saul Ewing Arnstein & Lehr	Legal	836
Healthcare Resources International	Legal	125
Winston & Strawn	Legal	2013
Lexis Nexis	Legal	9
Pretzel & Stouffer	Legal	29
Huntington Bank	Legal	6900
Baker Tilly Virchow Krause	Legal	693
Christoper P. Ryan	Legal	554
CliftonLarsonAllen	Accounting	1222
Ginoli & Co.	Accounting	433
Duane Morris	Accounting	71
Getzler Henrich & Associates	Accounting	938
Kemper Consulting	Accounting	71
Baker Tilly Virchow Krause	Accounting	494
Ginoli & Co.	Accounting	1993
Miscellaneous	Computer Services	112
Change Healthcare	Computer Services	4
TR Professional	Computer Services	12
Matrix Care	Computer Services	1372
Ability Network	Computer Services	2172
Stratus Networks	Computer Services	531
Kemper Technology	Computer Services	610
AT&T	Computer Services	7
Ungerboeck Software	Computer Services	439
CIAN	Computer Services	191
Comcast	Computer Services	47
CCH	Computer Services	18
Charter Communications	Computer Services	32
Allscripts	Computer Services	617
ATS	Computer Services	287
Citrix Systems	Computer Services	100
Optimizer	Other Prof Fees	56
Sedgwick CLMS	Other Prof Fees	193
David Budde	Other Prof Fees	55
Sargent Consulting	Other Prof Fees	152
Alix Partners	Other Prof Fees	576
Getzler Henrich & Associates	Other Prof Fees	78
Sargent Consulting	Other Prof Fees	22583
Alix Partners	Other Prof Fees	13973
Total (agree to Schedule V, line 19, column 8)		<u>67,252</u>

**Sullivan Health Care Center**

**0046425**

**Period Beginning** 1/1/2018

**Period End** 12/31/2018

**Schedule 21B**

**25. Administrative and Staff Transportation**

Gas	\$ 7,863
Auto Repairs	2,382
Home Office Allocation	<u>4,395</u>
	<u><u>14,640</u></u>

Facility Name &amp; ID Number Sullivan Health Care Center

# 0046425

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. IHCA-
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 7 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 26,759 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. \$ 195,270  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,380
- (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. \$ 6,349  
c. What percent of all travel expense relates to transportation of nurses and patients? 100  
d. Have vehicle usage logs been maintained? Adequate records have been maintained.  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes  
g. Does the facility transport residents to and from day training? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Ginoli and Company
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. No  
Attach invoices and a summary of services for all architect and appraisal fees