

		FOR BHF USE					

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2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

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.

<p>I. IDPH License ID Number: <u>0053470</u></p> <p>Facility Name: <u>Collinsville Rehabilitation & Health Care Center</u></p> <p>Address: <u>614 North Summit</u> <u>Collinsville</u> <u>62234</u> <small>Number City Zip Code</small></p> <p>County: <u>Madison</u></p> <p>Telephone Number: <u>(618) 344-8476</u> Fax # <u>(618) 344-8483</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>07/25/2006</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Mike Kocher</u> Telephone Number: <u>(309) 689-5850</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2017</u> to <u>12/31/2017</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;"> (Signed) _____ (Type or Print Name) <u>Mark B. Petersen</u> (Title) <u>Chief Executive Officer</u> </td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;"> (Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # <u>()</u> </td> </tr> </table> <p align="right"> 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 </p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Mark B. Petersen</u> (Title) <u>Chief Executive Officer</u>	Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # <u>()</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Mark B. Petersen</u> (Title) <u>Chief Executive Officer</u>							
Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # <u>()</u>							

Facility Name & ID Number Collinsville Rehabilitation & Health Care Center

0053470 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	98	Skilled (SNF)	98	35,770	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	98	TOTALS	98	35,770	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	23,577	180	1,007	24,764	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,577	180	1,007	24,764	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.23%

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)

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 7/25/2006

J. Was the facility purchased or leased after January 1, 1978?
 YES Date 7/25/2006 NO

K. Was the facility certified for Medicare during the reporting year?
 YES NO If YES, enter number of beds certified 98 and days of care provided 868

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: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number Collinsville Rehabilitation & Health Care Ctr # 0053470 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	131,407	18,497		149,904		149,904	5,559	155,463		1
2	Food Purchase		146,772		146,772		146,772	(267)	146,505		2
3	Housekeeping	155,253	29,838		185,091		185,091	84	185,175		3
4	Laundry	9,148	11,528		20,676		20,676		20,676		4
5	Heat and Other Utilities			71,479	71,479		71,479	292	71,771		5
6	Maintenance	48,724	6,813	13,242	68,779		68,779	2,627	71,406		6
7	Other (specify):* <u>Home Office Ben. Allocation</u>										7
8	TOTAL General Services	344,532	213,448	84,721	642,701		642,701	8,295	650,996		8
	B. Health Care and Programs										
9	Medical Director			14,400	14,400		14,400		14,400		9
10	Nursing and Medical Records	1,065,410	119,762	6,742	1,191,914		1,191,914	(3,542)	1,188,372		10
10a	Therapy		17	178,009	178,026		178,026		178,026		10a
11	Activities	44,460	990		45,450		45,450	(4,601)	40,849		11
12	Social Services	36,444			36,444		36,444		36,444		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Office Ben. Allocation</u>										15
16	TOTAL Health Care and Programs	1,146,314	120,769	199,151	1,466,234		1,466,234	(8,143)	1,458,091		16
	C. General Administration										
17	Administrative			254,100	254,100		254,100	(194,100)	60,000		17
18	Directors Fees										18
19	Professional Services			24,587	24,587		24,587	57,804	82,391		19
20	Dues, Fees, Subscriptions & Promotions			7,600	7,600		7,600	130	7,730		20
21	Clerical & General Office Expenses	28,562	4,370	13,450	46,382		46,382	59,760	106,142		21
22	Employee Benefits & Payroll Taxes			191,409	191,409		191,409	26,913	218,322		22
23	Inservice Training & Education							166	166		23
24	Travel and Seminar							82	82		24
25	Other Admin. Staff Transportation			2,571	2,571		2,571	3,984	6,555		25
26	Insurance-Prop.Liab.Malpractice			31,059	31,059		31,059	1,056	32,115		26
27	Other (specify):* <u>Home Office Ben. Allocation</u>										27
28	TOTAL General Administration	28,562	4,370	524,776	557,708		557,708	(44,205)	513,503		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,519,408	338,587	808,648	2,666,643		2,666,643	(44,053)	2,622,590		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

Collinsville Rehabilitation & Health Care Center

#0053470

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			85,916	85,916		85,916	5,826	91,742			30
31	Amortization of Pre-Op. & Org.							9,322	9,322			31
32	Interest			63,291	63,291		63,291	47,792	111,083			32
33	Real Estate Taxes			47,137	47,137		47,137	319	47,456			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			27,053	27,053		27,053	1,689	28,742			35
36	Other (specify):*											36
37	TOTAL Ownership			223,397	223,397		223,397	64,948	288,345			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		28,534		28,534		28,534		28,534			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			198,262	198,262		198,262		198,262			42
43	Other (specify):*		23	151,824	151,847		151,847	(151,847)				43
44	TOTAL Special Cost Centers		28,557	350,086	378,643		378,643	(151,847)	226,796			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,519,408	367,144	1,382,131	3,268,683		3,268,683	(130,952)	3,137,731			45

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

Collinsville Rehabilitation & Health Care Center

ID# 0053470

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (2,958)	43	1
2	X-Rays-Part A	(2,141)	43	2
3	Offset Transportation Revenue	(4,601)	11	3
4	Offset Miscellaneous Office Supplies Revenue	(74)	21	4
5	Disallowed Special Events	(535)	43	5
6	Offset Miscellaneous Nursing Supplies Revenue	(3,619)	10	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
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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	(13,928)		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%	\$ 5,559	\$ 5,559	1
2	V	2 Food		Petersen Health Care Management, Inc.	100.00%	24	24	2
3	V	3 Housekeeping		Petersen Health Care Management, Inc.	100.00%	84	84	3
4	V	5 Utilities		Petersen Health Care Management, Inc.	100.00%	292	292	4
5	V	6 Maintenance		Petersen Health Care Management, Inc.	100.00%	2,627	2,627	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%	77	77	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	254,100	Petersen Health Care Management, Inc.	100.00%	60,000	(194,100)	11
12	V	19 Professional Services		Petersen Health Care Management, Inc.	100.00%	17,410	17,410	12
13	V							13
14	Total		\$ 254,100			\$ 86,073	\$ * (168,027)	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 Dues, Fees, Subs & Promotions	\$	Petersen Health Care Management, Inc.	100.00%	\$ 130	\$	130	15
16	V	21 Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	59,834		59,834	16
17	V	22 Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	26,913		26,913	17
18	V	23 Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	166		166	18
19	V	24 Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	82		82	19
20	V	25 Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	3,984		3,984	20
21	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	1,056		1,056	21
22	V	30 Depreciation		Petersen Health Care Management, Inc.	100.00%	14,249		14,249	22
23	V	31 Amortization		Petersen Health Care Management, Inc.	100.00%	128		128	23
24	V	32 Interest		Petersen Health Care Management, Inc.	100.00%	463		463	24
25	V	33 Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	319		319	25
26	V	35 Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	1,689		1,689	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		\$			\$ 109,013	\$ *	109,013	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 Business, LLC	100.00%	\$ 0	\$	15	
16	V	2 Food		Petersen Health Business, LLC	100.00%	0		16	
17	V	3 Housekeeping		Petersen Health Business, LLC	100.00%	0		17	
18	V	4 Laundry		Petersen Health Business, LLC	100.00%	0		18	
19	V	5 Utilities		Petersen Health Business, LLC	100.00%	0		19	
20	V	6 Maintenance		Petersen Health Business, LLC	100.00%	0		20	
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Business, LLC	100.00%	0		21	
22	V	10 Nursing and Medical Records		Petersen Health Business, LLC	100.00%	0		22	
23	V	15 Mgmt. Allocation of Benefits		Petersen Health Business, LLC	100.00%	0		23	
24	V	17 Administrative		Petersen Health Business, LLC	100.00%	0		24	
25	V	19 Professional Services		Petersen Health Business, LLC	100.00%	41,894	41,894	25	
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Business, LLC	100.00%	0		26	
27	V	21 Clerical and General Office		Petersen Health Business, LLC	100.00%	0		27	
28	V	22 Employee Benefits & Payroll		Petersen Health Business, LLC	100.00%	0		28	
29	V	23 Inservice Training & Education		Petersen Health Business, LLC	100.00%	0		29	
30	V	24 Travel and Seminar		Petersen Health Business, LLC	100.00%	0		30	
31	V	25 Other Admin. Staff Transport.		Petersen Health Business, LLC	100.00%	0		31	
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Business, LLC	100.00%	0		32	
33	V	30 Depreciation		Petersen Health Business, LLC	100.00%	0		33	
34	V	31 Amortization		Petersen Health Business, LLC	100.00%	9,194	9,194	34	
35	V	32 Interest		Petersen Health Business, LLC	100.00%	48,654	48,654	35	
36	V	33 Real Estate Taxes		Petersen Health Business, LLC	100.00%	0		36	
37	V	34 Rent-Facility and Grounds		Petersen Health Business, LLC	100.00%	0		37	
38	V	35 Rent-Equipment & Vehicles		Petersen Health Business, LLC	100.00%	0		38	
39	Total		\$			\$ 99,742	\$ *	99,742	39

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

Facility Name & ID Number

Collinsville Rehabilitation & Health Care Center

0053470

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			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 System	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	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 Busine	Peoria	Mgmt/Bookkeeping	11
12			Countryview Terrace	Louisville	Petersen Health Care	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care	Peoria	Lessor	13
14			Decatur Rehab & Health Care Center	Decatur	Midwest Health Opera	Peoria	Mgmt/Bookkeeping	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Health Prope	Peoria	Mgmt/Bookkeeping	15
16			Eastview Terrace	Sullivan	Petersen Roseville, LL	Roseville	Lessor	16
17			El Paso Health Care Center	El Paso	Petersen Health Juncti	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Petersen Health Qualit	Peoria	Mgmt/Bookkeeping	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Health and W	Peoria	Mgmt/Bookkeeping	19
20			Flanagan Rehab & Health Care Center	Flanagan	Petersen 24, LLC	Peoria	Hospitality	20
21			Flora Gardens Care Center	Flora				21
22			Flora Health Care Center	Flora				22
23			Fondulac Rehab & Health Care Center	East Peoria				23
24			Havana Health Care Center	Havana				24
25			Illini Heritage Rehab & Health Care	Champaign				25
26			Jonesboro Rehab & Health Care Center	Jonesboro				26
27			Kewanee Care Home	Kewanee				27
28			LaHarpe Davier Health Care Center	LaHarpe				28
29			Lebanon Care Center	Lebanon				29
30			Marigold Rehab & Health Care Center	Galesburg				30

Facility Name & ID Number

Collinsville Rehabilitation & Health Care Center

0053470

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			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

Collinsville Rehabilitation & Health Care Center

0053470

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 Collinsville Rehabilitation & Health Care Ce # 0053470 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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 Collinsville Rehabilitation & Health Care Center # 0053470 Report Period Beginning: 1/1/2017 Ending: 2/31/2017

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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	1,451,714	75	\$ 325,901	\$ 376,129	24,764	\$ 5,559	1
2	2	Food	Resident Days	1,451,714	75	1,404	0	24,764	24	2
3	3	Housekeeping	Resident Days	1,451,714	75	4,904	2,743	24,764	84	3
4	5	Utilities	Resident Days	1,451,714	75	17,131	0	24,764	292	4
5	6	Maintenance	Resident Days	1,451,714	75	153,997	146,594	24,764	2,627	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,451,714	75	0	0	24,764	0	6
7	9	Medical Director	Resident Days	1,451,714	75	0	0	24,764	0	7
8	10	Nursing and Medical Records	Resident Days	1,451,714	75	4,528	1,833,909	24,764	77	8
9	10A	Therapy	Resident Days	1,451,714	75	0	0	24,764	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,451,714	75	0	0	24,764	0	10
11	17	Administrative	Resident Days	1,451,714	75	4,871,788	5,558,349	24,764	60,000	11
12	19	Professional Services	Resident Days	1,451,714	75	1,020,623	0	24,764	17,410	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,451,714	75	7,613	0	24,764	130	13
14	21	Clerical and General Office	Resident Days	1,451,714	75	3,507,569	3,782,761	24,764	59,834	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,451,714	75	1,577,706	0	24,764	26,913	15
16	23	Inservice Training & Education	Resident Days	1,451,714	75	9,731	0	24,764	166	16
17	24	Travel and Seminar	Resident Days	1,451,714	75	4,833	0	24,764	82	17
18	25	Other Admin. Staff Transport.	Resident Days	1,451,714	75	233,560	0	24,764	3,984	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,451,714	75	61,886	0	24,764	1,056	19
20	30	Depreciation	Resident Days	1,451,714	75	835,302	0	24,764	14,249	20
21	31	Amortization	Resident Days	1,451,714	75	7,526	0	24,764	128	21
22	32	Interest	Resident Days	1,451,714	75	27,155	0	24,764	463	22
23	33	Real Estate Taxes	Resident Days	1,451,714	75	18,716	0	24,764	319	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,451,714	75	99,030	0	24,764	1,689	24
25	TOTALS					\$ 12,790,903	\$ 11,700,485		\$ 195,086	25

Facility Name & ID Number Collinsville Rehabilitation & Health Care Center # 0053470 Report Period Beginning: 1/1/2017 Ending: 2/31/2017

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	149,328	9	\$	\$	24,764	\$	1
2	2	Food	Resident Days	149,328	9			24,764		2
3	3	Housekeeping	Resident Days	149,328	9			24,764		3
4	4	Laundry	Resident Days	149,328	9			24,764		4
5	5	Utilities	Resident Days	149,328	9			24,764		5
6	6	Maintenance	Resident Days	149,328	9			24,764		6
7	7	Mgmt. Allocation of Benefits	Resident Days	149,328	9			24,764		7
8	10	Nursing and Medical Records	Resident Days	149,328	9			24,764		8
9	15	Mgmt. Allocation of Benefits	Resident Days	149,328	9			24,764		9
10	17	Administrative	Resident Days	149,328	9			24,764		10
11	19	Professional Services	Resident Days	149,328	9	252,621		24,764	41,894	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	149,328	9			24,764		12
13	21	Clerical and General Office	Resident Days	149,328	9			24,764		13
14	22	Employee Benefits & Payroll	Resident Days	149,328	9			24,764		14
15	23	Inservice Training & Education	Resident Days	149,328	9			24,764		15
16	24	Travel and Seminar	Resident Days	149,328	9			24,764		16
17	25	Other Admin. Staff Transport.	Resident Days	149,328	9			24,764		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	149,328	9			24,764		18
19	30	Depreciation	Resident Days	149,328	9			24,764		19
20	31	Amortization	Resident Days	149,328	9	55,441		24,764	9,194	20
21	32	Interest	Resident Days	149,328	9	293,387		24,764	48,654	21
22	33	Real Estate Taxes	Resident Days	149,328	9			24,764		22
23	34	Rent-Facility and Grounds	Resident Days	149,328	9			24,764		23
24	35	Rent-Equipment & Vehicles	Resident Days	149,328	9			24,764		24
25	TOTALS					\$ 601,449	\$		\$ 99,742	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	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	Bank Leumi		X	Mortgage	Varies	1/1/15	\$ 1,368,750	\$ 1,235,111	12/31/24	Varies	\$ 63,291	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related						\$ 1,368,750	\$ 1,235,111			\$ 63,291	9								
B. Non-Facility Related*																				
10							Interest Income Offset				(1,325)	10								
11							Home Office Allocation-PHB				48,654	11								
12							Home Office Allocation-PHCM				463	12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$ 47,792	14								
15	TOTALS (line 9+line14)						\$ 1,368,750	\$ 1,235,111			\$ 111,083	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.)

Facility Name & ID Number Collinsville Rehabilitation & Health Care Center

0053470 Report Period Beginning:

1/1/2017 Ending:

12/31/2017

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 29,350 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

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

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

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

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

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

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

N/A

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

1. Total Amount Incurred: 295,295 2. Number of Years Over Which it is Being Amortized: 5 3. Current Period Amortization: 9,322 4. Dates Incurred: 2010-2012 Home Office Refinancing

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

XI. OWNERSHIP COSTS:

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Row 1: Facility, 391,343, 2006, \$ 40,000, 1. Row 2: (blank), (blank), (blank), (blank), 2. Row 3: TOTALS, 391,343, (blank), \$ 40,000, 3.

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	100	2006	1962	\$ 1,635,299	\$	30	\$ 54,510	\$ 34,053	\$ 626,865	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Wheelchair Ramp		2007	2,530		15	169	169	1,774	9
10	Fountain		2007	1,269		15	85	85	892	10
11	Exit Signs		2007	612		7			612	11
12	Blinds		2007	4,886		10	241	241	4,886	12
13	Exit Signs		2008	690		15	46	46	437	13
14	Boiler		2009	6,500		7			6,500	14
15	Sprinkler Repair		2009	22,880		7			22,880	15
16	Boiler		2010	11,339		15	756	756	8,182	16
17	A/C Unit		2010	6,260		15	418	418	3,135	17
18	Roof Replacement		2010	69,464		25	2,778	2,778	20,835	18
19	Nurse Call Light System		2011	6,260		10	626	626	4,069	19
20	Ceiling Repair		2011	2,575		7	368	368	2,392	20
21	Roof Replacement-Completion of 2010 Work		2011	44,923		25	1,796	1,796	11,674	21
22	Roof Repairs		2012	3,047		7	436	436	2,398	22
23	Roof and Gutter Replacement		2012	64,790		25	2,592	2,592	14,256	23
24	Roof Repairs		2013	9,793		7	1,400	1,400	6,300	24
25	Condensing Unit		2014	4,500		7	643	643	2,251	25
26	Flooring Replacement-Dining Room and Common Area		2015	15,946		15	1,064	1,064	2,660	26
27	Call Light Replacement System		2015	12,001		7	857	857	1,714	27
28	Fire Alarm Replacement System		2015	6,383		7	456	456	912	28
29	Water Heater		2016	4,054		7	580	580	870	29
30	Sod Installation		2016	12,903		10	1,290	1,290	1,935	30
31	Water Heater		2017	4,321		7	309	309	309	31
32										32
33										33
34										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		\$	\$		\$	\$	\$
38							
39							
40							
41							
42							
43							
44							
45							
46							
47							
48							
49							
50							
51							
52							
53							
54							
55							
56							
57							
58							
59							
60							
61			253			(253)	
62			65,634			(65,634)	
63			16,134			(16,134)	
64							
65		11,327			272	272	
66		142			68	68	
67							
68							
69							
70		\$ 1,964,694	\$ 82,021		\$ 71,760	\$ (30,718)	\$ 748,738

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

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	\$ 66,929	\$ 3,895	\$ 6,073	\$ 2,178	5-10 yrs.	\$ 46,726	71
72	Current Year Purchases					7 yrs.		72
73	Fully Depreciated Assets	185,000					185,000	73
74	Home Office Allocation			13,909	13,909			74
75	TOTALS	\$ 251,929	\$ 3,895	\$ 19,982	\$ 16,087		\$ 231,726	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76					\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,256,623	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 85,916	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 91,742	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 5,826	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 980,464	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					87
88					88
89	N/A				89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	Nurse Station Remodeling	\$ 24,475	92
93			93
94			94
95		\$ 24,475	95

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

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

Facility Name & ID Number Collinsville Rehabilitation & Health Care Center

0053470

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.

YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12.	_____ /2018	\$ _____
13.	_____ /2019	\$ _____
14.	_____ /2020	\$ _____

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: \$ 24,459 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	<u>Facility</u>	<u>2015 Ford E150</u>	\$ <u>570.75</u>	\$ <u>4,283</u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u>570.75</u>	\$ <u>4,283</u>	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.

**Collinsville Rehabilitation & Health Care Center
0053470**

Period Beginning 1/1/2017
Period End 12/31/2017

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$	16,199
Dishwasher		701
Copier		5,870
Home Office Allocation		1,689
		<u>24,459</u>

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	5,245	\$ 78,678	\$	5,245	\$ 78,678	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		977	14,659		977	14,659	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		5,645	84,672	17	5,645	84,689	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				28,534		28,534	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			\$	11,867	\$ 178,009	\$ 28,551	11,867	\$ 206,560	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 Collinsville Rehabilitation & Health Care Center# 0053470Report Period Beginning: 1/1/2017Ending: 12/31/2017

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2017

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (2,384,691)	\$ (2,384,691)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>235,063</u>)	2,176,539	2,176,539	3
4	Supply Inventory (priced at <u>Cost</u>)	10,390	10,390	4
5	Short-Term Investments			5
6	Prepaid Insurance	21,587	21,587	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (176,175)	\$ (176,175)	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	43,799	40,000	13
14	Buildings, at Historical Cost	1,635,299	1,646,626	14
15	Leasehold Improvements, at Historical Cost	264,319	318,068	15
16	Equipment, at Historical Cost	251,929	251,929	16
17	Accumulated Depreciation (book methods)	(1,089,449)	(980,464)	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 (spe <u>Const. in Progress</u>)	24,475	24,475	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,130,372	\$ 1,300,634	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 954,197	\$ 1,124,459	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 546,363	\$ 546,363	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	85,846	85,846	30
31	Accrued Taxes Payable (excluding real estate taxes)	45,006	45,006	31
32	Accrued Real Estate Taxes(Sch.IX-B)	46,968	46,968	32
33	Accrued Interest Payable	5,318	5,318	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	1,436	1,436	36
37	<u>Accrued Management Fees</u>	492,112	492,112	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,223,049	\$ 1,223,049	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,235,111	1,235,111	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Intercompany Loans</u>	3,011	3,011	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,238,122	\$ 1,238,122	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,461,171	\$ 2,461,171	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,506,974)	\$ (1,336,712)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 954,197	\$ 1,124,459	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,887,855)	1
2	Restatements (describe):		2
3	Adjustments Made After Cost Reports Were Filed	9,806	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,878,049)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	371,075	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)	\$ 371,075	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)	\$ (1,506,974)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Collinsville Rehabilitation & Health Care Center

0053470

Report Period Beginning: 1/1/2017

Ending:

12/31/2017

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		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,369,238	1
2	Discounts and Allowances for all Levels	(153,619)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,215,619	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	329,332	6
7	Oxygen	112	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 329,444	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	291	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	68,319	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	7,238	20
21	Other Medical Services	9,220	21
22	Laundry	8	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 85,076	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,325	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,325	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Transportation Revenue</u>	4,601	28
28a	<u>Miscellaneous Revenue</u>	3,693	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 8,294	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,639,758	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	642,701	31
32	Health Care	1,466,234	32
33	General Administration	557,708	33
B. Capital Expense			
34	Ownership	223,397	34
C. Ancillary Expense			
35	Special Cost Centers	180,381	35
36	Provider Participation Fee	198,262	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,268,683	40
41	Income before Income Taxes (line 30 minus line 40)**	371,075	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 371,075	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 2,937,652	44
45	Private Pay - Net Inpatient Revenue	101,602	45
46	Medicare - Net Inpatient Revenue	138,345	46
47	Other-(specify) <u>Insurance Net Inpatient Revenue</u>	38,020	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,215,619	49

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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 Collinsville Rehabilitation & Health Care Center

0053470

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

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	683	683	\$ 22,692	\$ 33.22	1
2	Assistant Director of Nursing	40	40	1,212	30.30	2
3	Registered Nurses	2,201	2,213	55,867	25.24	3
4	Licensed Practical Nurses	16,650	17,214	328,838	19.10	4
5	CNAs & Orderlies	40,764	41,560	499,377	12.02	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,825	1,825	23,401	12.82	9
10	Activity Assistants					10
11	Social Service Workers	2,080	2,080	36,444	17.52	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	33,350	16.03	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,138	10,542	98,057	9.30	15
16	Dishwashers					16
17	Maintenance Workers	1,964	2,079	48,724	23.44	17
18	Housekeepers	16,267	16,382	155,253	9.48	18
19	Laundry	1,008	1,056	9,148	8.66	19
20	Administrator	2,080	2,080	60,000	28.85	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,872	1,903	28,562	15.01	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Page 20A</u>	8,841	9,048	178,483	19.73	33
34	TOTAL (lines 1 - 33)	108,493	110,785	\$ 1,579,408 *	\$ 14.26	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 14,400	L9,C3	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 6,511	L10, C3	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant	4 231	L10, C3	42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	4 \$ 21,142		49

C. CONTRACT NURSES

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

Collinsville Rehabilitation & Health Care Center

0053470

Period Beginning 1/1/2017

Period End 12/31/2017

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	4,869	4,893	131,252	26.82
Transportation	2,000	2,048	21,059	10.28
Restorative Nurse	1,972	2,107	26,172	12.42
TOTAL	8,841	9,048	178,483	

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	
LaWanna Kiefer	Administrator	0	\$ 60,000	Workers' Compensation Insurance	\$ 35,050	IDPH License Fee	\$ 3,980	
				Unemployment Compensation Insurance	38,424	Advertising: Employee Recruitment	505	
				FICA Taxes	114,763	Health Care Worker Background Check (Indicate # of checks performed <u>156</u>)	1,597	
				Employee Health Insurance	1,987	Miscellaneous Licenses & Permits	566	
				Employee Meals		Miscellaneous Dues & Subscriptions	952	
				Illinois Municipal Retirement Fund (IMRF)*		Home Office Allocation	130	
				Employee Relations	856			
				Employee Retirement	329			
				Home Office Allocation	26,913			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 60,000	TOTAL (agree to Schedule V, line 22, col.8)		\$ 7,730		
B. Administrative - Other							Less: Public Relations Expense ()	
Description			Amount				Non-allowable advertising ()	
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 254,100				Yellow page advertising ()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 254,100				TOTAL (agree to Sch. V, line 20, col. 8)	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Sorling Northrup	Legal Fees		\$ 14,515				Out-of-State Travel	\$
Boyle Brasher	Legal Fees		139					
Charter Communications	Computer Services		864					
Honkamp Krueger & Co.	Accounting Fees		3,002	N/A			In-State Travel	
Ability Network	Computer Services		4,567					
Meyer Jensen	Settlement		1,500				Seminar Expense	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 24,587	TOTAL		\$	Home Office Allocation	82
							Entertainment Expense ()	
							TOTAL (agree to Sch. V, line 24, col. 8)	
							\$ 82	

* Attach copy of IMRF notifications

**See instructions.

Collinsville Rehabilitation & Health Care Center**0053470****Period Beginning****1/1/2017****Period End****12/31/2017****Schedule 21A****XIX. SUPPORT SCHEDULE****C. Professional Services**

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		24,587
Home Office Allocation		
MusilloUnkenholt, LLC	Legal	199
Arnstein & Lehr	Legal	1337
SB2	Legal	840
Miscellaneous	Legal	15
Miller Hall and Triggs	Legal	213
Smith Amundsen	Legal	83
Healthcare Resources International	Legal	147
Hunziker Law	Legal	1
Lexis Nexis	Legal	8
Baker Tilly Virchow Krause	Legal	746
Applegate, Thorne, Thompson	Legal	2712
Duane Morris	Legal	802
Gemino	Legal	4409
Morgan, Cohen, Bach	Legal	1736
Peoria County Recorder	Legal	8
CliftonLarsonAllen	Accounting	2389
Ginoli & Co.	Accounting	3380
Baker Tilly Virchow Krause	Accounting	149
Gemino	Accounting	2435
Miscellaneous	Computer Services	114
Change Healthcare	Computer Services	9
360 Networks	Computer Services	46
Matrix Care	Computer Services	4167
Stratus Networks	Computer Services	498
Kemper Technology	Computer Services	282
AT&T	Computer Services	7
Ability Network	Computer Services	307
CIAN	Computer Services	346
Comcast	Computer Services	19
CCH	Computer Services	17
Charter Communications	Computer Services	35
Allscripts	Computer Services	308
ATS	Computer Services	317
Citrix Systems	Computer Services	29
Optimizer	Other Prof Fees	56
Ankura	Other Prof Fees	897
David Budde	Other Prof Fees	42
Sargent Consulting	Other Prof Fees	15240
Alix Partners	Other Prof Fees	14739
Demonica Kemper	Other Prof Fees	37
Brad Barkley	Other Prof Fees	147
MPAC Healthcare	Other Prof Fees	22
Higgs Appraisal	Other Prof Fees	10
Alan Litwiller	Other Prof Fees	4
Total (agree to Schedule V, line 19, column 8)		<u>83,891</u>

Collinsville Rehabilitation & Health Care Center

=PG21A!A2

Period Beginning

1/1/2017

Period End

12/31/2017

Schedule 21A

XIX. SUPPORT SCHEDULE

Legal Fees

Home Office Allocation-PMC & PHCM

MusilloUnkenholt, LLC	Legal	199
Arnstein & Lehr	Legal	1337
SB2	Legal	840
Miscellaneous	Legal	15
Miller Hall and Triggs	Legal	213
Smith Amundsen	Legal	83
Healthcare Resources International	Legal	147
Hunziker Law	Legal	1
Lexis Nexis	Legal	8
Baker Tilly Virchow Krause	Legal	746
Applegate, Thorne, Thompson	Legal	2712
Duane Morris	Legal	802
Gemino	Legal	4409
Morgan, Cohen, Bach	Legal	1736
Peoria County Recorder	Legal	8

Direct Facility Invoices

Sorling Northrup-B. Thomas Case	5/5/2017	2,227
Sorling Northrup-B. Thomas Case	6/7/2017	1,650
Sorling Northrup-B. Thomas Case	7/11/2017	3,300
Meyer Jensen-Settlement	9/19/2017	1,500
Boyle Brasher-B.Thomas Cfse	10/3/2017	139
Sorling Northrup-B. Thomas Case	10/10/2017	6,062
Sorling Northrup-B. Thomas Case	11/8/2017	1,276
Less Settlement		(1,500)

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

27,910

Facility Name & ID Number Collinsville Rehabilitation & Health Care Center# 0053470Report Period Beginning: 1/1/2017Ending: 12/31/2017**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-\$952
- (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. \$ 22,667 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. \$ 198,262
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. \$ 291
- (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. \$ 4,272
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? Yes**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 329
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli and Company
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees