



Facility Name & ID Number Piper City Rehabilitation and Living Center

# 0050773 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	60	Skilled (SNF)	60	21,900	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	60	TOTALS	60	21,900	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	8,720	5,688	1,240	15,648	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,720	5,688	1,240	15,648	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.45%

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)

Independent Living, 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 1/1/2010

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

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 60 and days of care provided 1,165

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 Piper City Rehabilitation and Living Center # 0050773 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	159,409	13,907		173,316		173,316	(27,189)	146,127		1
2	Food Purchase		126,145		126,145		126,145	(24,956)	101,189		2
3	Housekeeping	105,620	17,845		123,465		123,465	(22,016)	101,449		3
4	Laundry		7,192		7,192		7,192	(1,286)	5,906		4
5	Heat and Other Utilities			65,435	65,435		65,435	(11,506)	53,929		5
6	Maintenance	35,679	8,822	33,427	77,928		77,928	(12,444)	65,484		6
7	Other (specify):* <u>Home Office Ben. Allocation</u>										7
8	<b>TOTAL General Services</b>	<b>300,708</b>	<b>173,911</b>	<b>98,862</b>	<b>573,481</b>		<b>573,481</b>	<b>(99,397)</b>	<b>474,084</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			7,200	7,200		7,200		7,200		9
10	Nursing and Medical Records	886,698	56,210	6,064	948,972		948,972	2,270	951,242		10
10a	Therapy			250,780	250,780		250,780		250,780		10a
11	Activities	22,277	372	24	22,673		22,673	(10,491)	12,182		11
12	Social Services	35,863			35,863		35,863		35,863		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>	<b>944,838</b>	<b>56,582</b>	<b>264,068</b>	<b>1,265,488</b>		<b>1,265,488</b>	<b>(8,221)</b>	<b>1,257,267</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative			221,100	221,100		221,100	(147,478)	73,622		17
18	Directors Fees										18
19	Professional Services			3,389	3,389		3,389	23,106	26,495		19
20	Dues, Fees, Subscriptions & Promotions			2,883	2,883		2,883	2,819	5,702		20
21	Clerical & General Office Expenses	31,026	1,711	10,203	42,940		42,940	38,903	81,843		21
22	Employee Benefits & Payroll Taxes			132,899	132,899		132,899	16,378	149,277		22
23	Inservice Training & Education							95	95		23
24	Travel and Seminar							2	2		24
25	Other Admin. Staff Transportation			4,267	4,267		4,267	2,893	7,160		25
26	Insurance-Prop.Liab.Malpractice			22,759	22,759		22,759	725	23,484		26
27	Other (specify):* <u>Home Office Ben. Allocation</u>										27
28	<b>TOTAL General Administration</b>	<b>31,026</b>	<b>1,711</b>	<b>397,500</b>	<b>430,237</b>		<b>430,237</b>	<b>(62,557)</b>	<b>367,680</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,276,572</b>	<b>232,204</b>	<b>760,430</b>	<b>2,269,206</b>		<b>2,269,206</b>	<b>(170,175)</b>	<b>2,099,031</b>		<b>29</b>

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			56,649	56,649		56,649	2,354	59,003		30
31	Amortization of Pre-Op. & Org.							83	83		31
32	Interest			55,651	55,651		55,651	2,239	57,890		32
33	Real Estate Taxes			36,077	36,077		36,077	287	36,364		33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			13,299	13,299		13,299	1,288	14,587		35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			161,676	161,676		161,676	6,251	167,927		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		27,155		27,155		27,155		27,155		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			117,587	117,587		117,587		117,587		42
43	Other (specify):* <b>Miscellaneous</b>		32	42,847	42,879		42,879	(42,879)			43
44	<b>TOTAL Special Cost Centers</b>		27,187	160,434	187,621		187,621	(42,879)	144,742		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,276,572	259,391	1,082,540	2,618,503		2,618,503	(206,803)	2,411,700		45

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

**VI. ADJUSTMENT DETAIL**

**A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.**

**In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,437)	2		4
5	Telephone, TV & Radio in Resident Rooms	(7,010)	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	965	30		9
10	Interest and Other Investment Income	(186)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(154)	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	(20,194)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(12,001)	43		24
25	Fund Raising, Advertising and Promotional	173	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	(126,377)	Various		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (167,221)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(39,582)	Various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (39,582)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (206,803)		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

BHF USE ONLY							
48		49		50		51	
							52

Piper City Rehabilitation and Living Center

ID# 0050773

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (1,589)	43	1
2	X-Rays-Part A	(795)	43	2
3	Offset Miscellaneous Nursing Supplies Revenue	(360)	10	3
4	Offset Transportation Revenue	(10,491)	11	4
5	Offset Miscellaneous Office Supplies Revenue	(93)	21	5
6	Resident Flowers	(41)	43	6
7	Disallowed Special Events	(1,268)	43	7
8	Independent Living Dietary Cost Offset	(30,989)	1	8
9	Independent Living Food Cost Offset	(22,555)	2	9
10	Independent Living Housekeeping Cost Offset	(22,076)	3	10
11	Independent Living Laundry Cost Offset	(1,286)	4	11
12	Independent Living Utilities Cost Offset	(11,700)	5	12
13	Independent Living Maintenance Cost Offset	(13,934)	6	13
14	Independent Living Depreciation Cost Offset	(9,200)	30	14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
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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>	(126,377)		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%	\$ 3,800	\$ 3,800	1
2	V	2 Food		Petersen Health Care Management, Inc.	100.00%	36	36	2
3	V	3 Housekeeping		Petersen Health Care Management, Inc.	100.00%	60	60	3
4	V	5 Utilities		Petersen Health Care Management, Inc.	100.00%	194	194	4
5	V	6 Maintenance		Petersen Health Care Management, Inc.	100.00%	1,490	1,490	5
6	V	7 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		6
7	V	9 Medical Director		Petersen Health Care Management, Inc.	100.00%	0		7
8	V	10 Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	2,630	2,630	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	144,300	Petersen Health Care Management, Inc.	100.00%	73,622	(70,678)	11
12	V	19 Professional Services		Petersen Health Care Management, Inc.	100.00%	11,503	11,503	12
13	V							13
14	Total		\$ 144,300			\$ 93,335	\$ * (50,965)	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%	\$ 2,819	\$	2,819	15
16	V	21 <u>Clerical and General Office</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	38,996		38,996	16
17	V	22 <u>Employee Benefits and Payroll Taxes</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	16,378		16,378	17
18	V	23 <u>Inservice Training &amp; Education</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	95		95	18
19	V	24 <u>Travel and Seminar</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	2		2	19
20	V	25 <u>Other Admin. Staff Transport.</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	2,893		2,893	20
21	V	26 <u>Insurance-Prop./Liab./Malprac.</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	725		725	21
22	V	30 <u>Depreciation</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	9,223		9,223	22
23	V	31 <u>Amortization</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	83		83	23
24	V	32 <u>Interest</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	2,425		2,425	24
25	V	33 <u>Real Estate Taxes</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	287		287	25
26	V	35 <u>Rent-Equipment &amp; Vehicles</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	836		836	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>		\$			\$ 74,762	\$ *	74,762	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	\$	Midwest Health Operations, LLC	100.00%	\$ 0	\$
16	V	2 Food		Midwest Health Operations, LLC	100.00%	0	
17	V	3 Housekeeping		Midwest Health Operations, LLC	100.00%	0	
18	V	4 Laundry		Midwest Health Operations, LLC	100.00%	0	
19	V	5 Utilities		Midwest Health Operations, LLC	100.00%	0	
20	V	6 Maintenance		Midwest Health Operations, LLC	100.00%	0	
21	V	7 Mgmt. Allocation of Benefits		Midwest Health Operations, LLC	100.00%	0	
22	V	10 Nursing and Medical Records		Midwest Health Operations, LLC	100.00%	0	
23	V	15 Mgmt. Allocation of Benefits		Midwest Health Operations, LLC	100.00%	0	
24	V	17 Administrative	76,800	Midwest Health Operations, LLC	100.00%	0	(76,800)
25	V	19 Professional Services		Midwest Health Operations, LLC	100.00%	11,603	11,603
26	V	20 Dues, Fees, Subs & Promotions		Midwest Health Operations, LLC	100.00%	0	
27	V	21 Clerical and General Office		Midwest Health Operations, LLC	100.00%	0	
28	V	22 Employee Benefits & Payroll		Midwest Health Operations, LLC	100.00%	0	
29	V	23 Inservice Training & Education		Midwest Health Operations, LLC	100.00%	0	
30	V	24 Travel and Seminar		Midwest Health Operations, LLC	100.00%	0	
31	V	25 Other Admin. Staff Transport.		Midwest Health Operations, LLC	100.00%	0	
32	V	26 Insurance-Prop./Liab./Malprac.		Midwest Health Operations, LLC	100.00%	0	
33	V	30 Depreciation		Midwest Health Operations, LLC	100.00%	1,366	1,366
34	V	31 Amortization		Midwest Health Operations, LLC	100.00%	0	
35	V	32 Interest		Midwest Health Operations, LLC	100.00%	0	
36	V	33 Real Estate Taxes		Midwest Health Operations, LLC	100.00%	0	
37	V	34 Rent-Facility and Grounds		Midwest Health Operations, LLC	100.00%	0	
38	V	35 Rent-Equipment & Vehicles		Midwest Health Operations, LLC	100.00%	452	452
39	Total		\$ 76,800			\$ 13,421	\$ * (63,379)

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

Facility Name &amp; ID Number

Piper City Rehabilitation and Living Center

# 0050773

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 Syste	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

Piper City Rehabilitation and Living Center

# 0050773

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 Piper City Rehabilitation and Living Center # 0050773 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 Piper City Rehabilitation and Living Center # 0050773 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

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

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

1	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	15,648	\$ 3,800	1
2	2	Food	Resident Days	1,411,762	75	3,216	0	15,648	36	2
3	3	Housekeeping	Resident Days	1,411,762	75	5,441	2,652	15,648	60	3
4	5	Utilities	Resident Days	1,411,762	75	17,524	0	15,648	194	4
5	6	Maintenance	Resident Days	1,411,762	75	134,460	148,272	15,648	1,490	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,411,762	75	0	0	15,648	0	6
7	9	Medical Director	Resident Days	1,411,762	75	0	0	15,648	0	7
8	10	Nursing and Medical Records	Resident Days	1,411,762	75	237,275	1,454,984	15,648	2,630	8
9	10A	Therapy	Resident Days	1,411,762	75	0	0	15,648	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,411,762	75	0	0	15,648	0	10
11	17	Administrative	Resident Days	1,411,762	75	4,940,583	5,658,897	15,648	73,622	11
12	19	Professional Services	Resident Days	1,411,762	75	1,037,806	0	15,648	11,503	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,411,762	75	254,355	0	15,648	2,819	13
14	21	Clerical and General Office	Resident Days	1,411,762	75	3,518,216	3,764,024	15,648	38,996	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,411,762	75	1,477,639	0	15,648	16,378	15
16	23	Inservice Training & Education	Resident Days	1,411,762	75	8,601	0	15,648	95	16
17	24	Travel and Seminar	Resident Days	1,411,762	75	174	0	15,648	2	17
18	25	Other Admin. Staff Transport.	Resident Days	1,411,762	75	261,018	0	15,648	2,893	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,411,762	75	65,437	0	15,648	725	19
20	30	Depreciation	Resident Days	1,411,762	75	832,087	0	15,648	9,223	20
21	31	Amortization	Resident Days	1,411,762	75	7,528	0	15,648	83	21
22	32	Interest	Resident Days	1,411,762	75	218,814	0	15,648	2,425	22
23	33	Real Estate Taxes	Resident Days	1,411,762	75	25,901	0	15,648	287	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,411,762	75	75,380	0	15,648	836	24
25	TOTALS					\$ 13,464,326	\$ 11,422,040		\$ 168,097	25

Facility Name & ID Number Piper City Rehabilitation and Living Center

# 0050773

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 Midwest Health Operations, 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	84,622	6	\$	\$	15,648	\$	1
2	2	Food	Resident Days	84,622	6			15,648		2
3	3	Housekeeping	Resident Days	84,622	6			15,648		3
4	4	Laundry	Resident Days	84,622	6			15,648		4
5	5	Utilities	Resident Days	84,622	6			15,648		5
6	6	Maintenance	Resident Days	84,622	6			15,648		6
7	7	Mgmt. Allocation of Benefits	Resident Days	84,622	6			15,648		7
8	10	Nursing and Medical Records	Resident Days	84,622	6			15,648		8
9	15	Mgmt. Allocation of Benefits	Resident Days	84,622	6			15,648		9
10	17	Administrative	Resident Days	84,622	6			15,648		10
11	19	Professional Services	Resident Days	84,622	6	62,746		15,648	11,603	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	84,622	6			15,648		12
13	21	Clerical and General Office	Resident Days	84,622	6			15,648		13
14	22	Employee Benefits & Payroll	Resident Days	84,622	6			15,648		14
15	23	Inservice Training & Education	Resident Days	84,622	6			15,648		15
16	24	Travel and Seminar	Resident Days	84,622	6			15,648		16
17	25	Other Admin. Staff Transport.	Resident Days	84,622	6			15,648		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	84,622	6			15,648		18
19	30	Depreciation	Resident Days	84,622	6	7,386		15,648	1,366	19
20	31	Amortization	Resident Days	84,622	6			15,648		20
21	32	Interest	Resident Days	84,622	6			15,648		21
22	33	Real Estate Taxes	Resident Days	84,622	6			15,648		22
23	34	Rent-Facility and Grounds	Resident Days	84,622	6			15,648		23
24	35	Rent-Equipment & Vehicles	Resident Days	84,622	6	2,447		15,648	452	24
25	TOTALS					\$ 72,579	\$		\$ 13,421	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	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	Morton Community Bank		X	Mortgage	\$20,000.00	8/28/17	\$ 1,796,875	\$ 809,769	9/28/22	6.0000	\$ 55,651	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>				\$20,000.00		\$ 1,796,875	\$ 809,769			\$ 55,651	9						
<b>B. Non-Facility Related*</b>																		
10										Interest Income Offset	(186)	10						
11										Home Office Allocation-PHCM	2,425	11						
12												12						
13												13						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ 2,239	14						
15	<b>TOTALS (line 9+line14)</b>						\$ 1,796,875	\$ 809,769			\$ 57,890	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 Piper City Rehabilitation and Living Center COUNTY Ford

FACILITY IDPH LICENSE NUMBER 0050773

CONTACT PERSON REGARDING THIS REPORT MIKE KOCHER

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

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

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

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>04-04-03-300-003</u>	<u>Nursing Facility</u>	\$ <u>25,789.12</u>	\$ <u>25,789.12</u>
2. <u>04-04-03-302-003</u>	<u>Nursing Facility</u>	\$ <u>10,532.44</u>	\$ <u>10,532.44</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>36,321.56</u></u>	\$ <u><u>36,321.56</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 Piper City Rehabilitation and Living Center

# 0050773 Report Period Beginning:

1/1/2018 Ending:

12/31/2018

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 20,804 B. General Construction Type: Exterior Brick/Wood Frame Wood 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: 6,440 2. Number of Years Over Which it is Being Amortized: 5

3. Current Period Amortization: 83 4. Dates Incurred: January to December 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>20,804</u>	<u>2011</u>	<u>\$ 40,500</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>20,804</b>		<b>\$ 40,500</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	60	2011		\$ 744,500	\$	25	\$ 29,780	\$ 29,780	\$ 223,350	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Concrete Replacement		2010	7,606		15	508	508	3,810	9
10	Roof Replacement		2013	9,330		15	622	622	3,421	10
11	Alarm System Panel Replacement		2013	3,705		7	530	530	2,915	11
12	Generator		2014	20,000		15	1,333	1,333	5,999	12
13	Nurses Station		2014	13,750		15	917	917	4,127	13
14	Sprinkler system		2014	19,700		7	2,814	2,814	12,663	14
15	Tile for 4 Shower Stall Walls and Floors		2016	13,600		15	906	906	2,265	15
16	Foyer Repair & Mechanical Room Door Replacement		2016	5,000		7	714	714	1,785	16
17	Air Conditioner		2016	12,100		15	806	806	2,015	17
18	HVAC Rooftop Unit		2017	9,921		15	662	662	993	18
19	Sewer Line Repair		2017	4,397		7	628	628	942	19
20	Sewer Line Repair		2018	3,597		7	514	514	257	20
21	Air Conditioner-Rooftop		2018	9,653		15	322	322	322	21
22	Nurses Station Annunciator Panel		2018	2,846		7	203	203	203	22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30	Land Improvements Booked				507			(507)		30
31	Building Booked				29,780			(29,780)		31
32	Building Improvement Booked				11,004			(11,004)		32
33										33
34	2018-Home Office Allocation-Building Improvements			7,360			177	177		34
35	2018-Home Office Allocation-Land Improvements			738			47	47		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								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 887,803	\$ 41,291		\$ 41,483	\$ 192	\$ 265,067	70

\*\*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	\$ 64,208	\$ 5,804	\$ 6,978	\$ 1,174	5-10 yrs.	\$ 36,983	71
72	Current Year Purchases	2,477	354	177	(177)	7 yrs.	177	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			10,365	10,365			74
75	TOTALS	\$ 66,685	\$ 6,158	\$ 17,520	\$ 11,362		\$ 37,160	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)	\$ 994,988	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 47,449	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 59,003	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 11,554	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 302,227	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	Flooring for Assisted Living Facility	\$ 13,740	\$ 916	\$ 4,809	86
87	Assisted Living Facility	190,000	7,600	58,900	87
88	Foyer Repair	4,787	684	1,596	88
89					89
90					90
91	TOTALS	\$ 208,527	\$ 9,200	\$ 65,305	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: \$ 14,587 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.

**Piper City Rehabilitation and Living Center  
0050773**

**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	\$	8,809
Dishwasher		1,403
Copier		3,087
Home Office Allocation		1,288
		<u>14,587</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	\$	7,193	\$ 107,892	\$	7,193	\$ 107,892	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		974	14,612		974	14,612	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		8,552	128,276		8,552	128,276	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				27,155		27,155	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	<b>TOTAL</b>			\$	16,719	\$ 250,780	\$ 27,155	16,719	\$ 277,935	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 &amp; ID Number Piper City Rehabilitation and Living Center

# 0050773

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	\$ 4,348,625	\$ 4,348,625	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 69,757 )	338,723	338,723	3
4	Supply Inventory (priced at Cost )			4
5	Short-Term Investments			5
6	Prepaid Insurance	13,900	13,900	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	25,000	25,000	8
9	Other(specify): Security Deposit	1,992	1,992	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 4,728,240	\$ 4,728,240	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	40,500	40,500	13
14	Buildings, at Historical Cost	744,500	751,860	14
15	Leasehold Improvements, at Historical Cost	137,255	135,943	15
16	Equipment, at Historical Cost	66,685	66,685	16
17	Accumulated Depreciation (book methods)	(322,715)	(302,227)	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): Building-Assisted Living	143,222	143,222	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 809,447	\$ 835,983	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 5,537,687	\$ 5,564,223	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 486,934	\$ 486,934	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	74,575	74,575	30
31	Accrued Taxes Payable (excluding real estate taxes)	20,261	20,261	31
32	Accrued Real Estate Taxes(Sch.IX-B)	71,418	71,418	32
33	Accrued Interest Payable	3,562	3,562	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	Payroll Withholdings	409,220	409,220	36
37	Accrued Management Fees	1,377,328	1,377,328	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,443,298	\$ 2,443,298	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable	809,769	809,769	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	Intercompany Loans	391,970	391,970	43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 1,201,739	\$ 1,201,739	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 3,645,037	\$ 3,645,037	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,892,650	\$ 1,919,186	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 5,537,687	\$ 5,564,223	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>1,628,438</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Adjustments Made After Cost Reports Were Filed</b>	<b>(1,741)</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>1,626,697</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>265,953</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>265,953</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>1,892,650</b>	<b>24</b> *

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

**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	\$ 2,419,736	1
2	Discounts and Allowances for all Levels	(198,249)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,221,487	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients	133,789	5
6	Therapy	460,495	6
7	Oxygen	2,977	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 597,261	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	2,437	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	45,396	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	2,984	20
21	Other Medical Services	3,752	21
22	Laundry	9	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 54,578	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	186	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 186	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Transportation Revenue</u>	10,491	28
28a	<u>Miscellaneous Revenue</u>	453	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 10,944	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,884,456	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	573,481	31
32	Health Care	1,265,488	32
33	General Administration	430,237	33
<b>B. Capital Expense</b>			
34	Ownership	161,676	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	70,034	35
36	Provider Participation Fee	117,587	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,618,503	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	265,953	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 265,953	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,060,042	44
45	Private Pay - Net Inpatient Revenue	921,974	45
46	Medicare - Net Inpatient Revenue	234,269	46
47	Other-(specify) <u>Insurance Net Inpatient Revenue</u>	5,202	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 2,221,487	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 Piper City Rehabilitation and Living Center

# 0050773

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,869	1,869	\$ 61,288	\$ 32.79	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,557	2,777	80,356	28.94	3
4	Licensed Practical Nurses	11,128	11,445	303,039	26.48	4
5	CNAs & Orderlies	27,629	28,469	337,903	11.87	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,855	1,968	22,277	11.32	9
10	Activity Assistants					10
11	Social Service Workers	1,900	2,045	35,863	17.54	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	33,317	16.02	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,458	13,066	126,092	9.65	15
16	Dishwashers					16
17	Maintenance Workers	1,764	1,870	35,679	19.08	17
18	Housekeepers	8,434	8,690	105,620	12.15	18
19	Laundry					19
20	Administrator	2,352	2,352	73,622	31.30	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,003	2,118	31,026	14.65	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	178	178	5,502	30.91	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,080	2,080	34,325	16.50	31
32	Other Health Care(specify)					32
33	Other(specify) <u>CPC</u>	2,080	2,080	64,285	30.91	33
34	TOTAL (lines 1 - 33)	80,367	83,087	\$ 1,350,194 *	\$ 16.25	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 7,200	L9,C3	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 4,249	L10, C3	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant	2 150	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)	2 \$ 11,599		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

**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	
Sharon Bargmann	Administrator	0	\$ 9,886	Workers' Compensation Insurance	\$ 19,031	IDPH License Fee	\$	
Jennifer Holzhauser	Administrator	0	44,085	Unemployment Compensation Insurance	15,045	Advertising: Employee Recruitment		
Laurie Britt	Administrator	0	19,651	FICA Taxes	95,616	Health Care Worker Background Check		
				Employee Health Insurance	1,710	(Indicate # of checks performed <u>24</u> )	(32)	
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	2,915	
				Employee Relations	1,154	Home Office Allocation	2,819	
				Home Office Allocation	16,378			
				Employee Retirement	343			
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 73,622					
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
Description			Amount		\$ 149,277		\$ 5,702	
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 221,100			Less: Public Relations Expense	( )	
						Non-allowable advertising	( )	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 221,100	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
(Attach a copy of any management service agreement)				Description	Line #	Amount	Description	Amount
C. Professional Services							Out-of-State Travel	\$
Vendor/Payee	Type		Amount					
Frontier	Computer Services		\$ 2,253					
Ability Network	Computer Services		646					
All Scripts	Data Services		444					
Wells Fargo	Legal Filing Fees		46	N/A				
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	Seminar Expense	
(For legal fee disclosure, see page 39 of instructions)			\$ 3,389				Home Office Allocation	2
							Entertainment Expense	( )
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 2

\* Attach copy of IMRF notifications

\*\*See instructions.

**Piper City Rehabilitation and Living Center**

**0050773**

**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)		3,389

**Home Office Allocation**

Duane Morris	Legal	1572
Sedgwick CMS	Legal	139
SB2	Legal	388
Miscellaneous	Legal	116
Christoper P. Ryan	Legal	123
Saul Ewing Arnstein & Lehr	Legal	551
Healthcare Resources International	Legal	82
Winston & Strawn	Legal	1325
Lexis Nexis	Legal	6
Pretzel & Stouffer	Legal	19
Winston & Strawn	Legal	5996
CliftonLarsonAllen	Accounting	804
Ginoli & Co.	Accounting	285
Duane Morris	Accounting	47
Getzler Henrich & Associates	Accounting	618
Kemper Consulting	Accounting	47
Baker Tilly Virchow Krause	Accounting	325
Ginoli & Co.	Accounting	2186
Miscellaneous	Computer Services	74
Change Healthcare	Computer Services	3
TR Professional	Computer Services	8
Matrix Care	Computer Services	903
Ability Network	Computer Services	1430
Stratus Networks	Computer Services	350
Kemper Technology	Computer Services	401
AT&T	Computer Services	5
Ungerboeck Software	Computer Services	289
CIAN	Computer Services	126
Comcast	Computer Services	31
CCH	Computer Services	12
Charter Communications	Computer Services	21
Allscripts	Computer Services	406
ATS	Computer Services	189
Citrix Systems	Computer Services	66
Optimizer	Other Prof Fees	37
Sedgwick CLMS	Other Prof Fees	127
David Budde	Other Prof Fees	36
Sargent Consulting	Other Prof Fees	100
Alix Partners	Other Prof Fees	379
Getzler Henrich & Associates	Other Prof Fees	52
Alix Partners	Other Prof Fees	<u>3,432</u>

Total (agree to Schedule V, line 19, column 8)		<u>26,495</u>
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**Piper City Rehabilitation and Living Center  
0050773**

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

**Schedule 21B**

**25. Administrative and Staff Transportation**

Gas	\$	2,730
Auto Repairs		1,467
Mileage-Travel		70
Home Office Allocation		2,893
		<u>7,160</u>

Facility Name & ID Number Piper City Rehabilitation and Living Center# 0050773Report Period Beginning: 1/1/2018Ending: 12/31/2018**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. IHCA-
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 7 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 17,701 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. \$ 117,587  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,437
- (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. \$ 10,491  
c. What percent of all travel expense relates to transportation of nurses and patients? 100  
d. Have vehicle usage logs been maintained? Adequate records have been maintained.  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes  
g. Does the facility transport residents to and from day training? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Ginoli and Company
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. No  
Attach invoices and a summary of services for all architect and appraisal fees

Piper City Rehabilitation and Living Center

0050773

Period Beginning 1/1/2018

Period End 12/31/2018

Independent Living Offset

Schedule 23A

Census Days Summary:

	Days	%
Independent Living	3,407	17.88%
Nursing Home	15,648	82.12%
	<u>19,055</u>	<u>100.00%</u>

Expense Offset:	Total Amount	Ind. Liv %	Ind. Liv Offset	Basis For Allocation	Line
Dietary	173,316	17.88%	30,989	Census	1
Food	126,145	17.88%	22,555	Census	2
Housekeeping	123,465	17.88%	22,076	Census	3
Laundry	7,192	17.88%	1,286	Census	4
Utilities	65,435	17.88%	11,700	Census	5
Maintenance	77,928	17.88%	13,934	Census	6
Depreciation (Building)	<u>9,200</u>	100.00%	<u>9,200</u>	Beds	30
<b>Total</b>	<u>582,681</u>		<u>111,740</u>		

Note: Computed overhead cost of Independent Living based on census days. Independent Living depreciation expense was calculated based on total number of beds. Independent Living overhead and depreciation costs have been offset on P5A.