

Facility Name & ID Number South Elgin Rehabilitation & Health Care Center

0053140 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	14	Skilled (SNF)	14	5,110	1
2		Skilled Pediatric (SNF/PED)			2
3	76	Intermediate (ICF)	76	27,740	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	90	TOTALS	90	32,850	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		573	928	1,501	8
9	SNF/PED					9
10	ICF	22,846			22,846	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,846	573	928	24,347	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.12%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES 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 10/1/2005

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 14 and days of care provided 901

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 South Elgin Rehabilitation & Health Care Ce # 0053140 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	185,656	18,051	671	204,378		204,378	5,913	210,291		1
2	Food Purchase		156,934		156,934		156,934	55	156,989		2
3	Housekeeping	119,508	26,405		145,913		145,913	94	146,007		3
4	Laundry	649	6,034		6,683		6,683		6,683		4
5	Heat and Other Utilities			59,987	59,987		59,987	302	60,289		5
6	Maintenance	36,009	2,810	27,285	66,104		66,104	(2,073)	64,031		6
7	Other (specify):* <u>Home Office Ben. Allocation</u>										7
8	TOTAL General Services	341,822	210,234	87,943	639,999		639,999	4,291	644,290		8
	B. Health Care and Programs										
9	Medical Director			11,500	11,500		11,500		11,500		9
10	Nursing and Medical Records	1,332,129	144,949	118,113	1,595,191		1,595,191	975	1,596,166		10
10a	Therapy			473,386	473,386		473,386		473,386		10a
11	Activities	49,327	412	(56)	49,683		49,683	(1,004)	48,679		11
12	Social Services	46,935			46,935		46,935		46,935		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	1,428,391	145,361	602,943	2,176,695		2,176,695	(29)	2,176,666		16
	C. General Administration										
17	Administrative	41,667		315,700	357,367		357,367	(243,587)	113,780		17
18	Directors Fees										18
19	Professional Services			2,332	2,332		2,332	25,277	27,609		19
20	Dues, Fees, Subscriptions & Promotions			4,013	4,013		4,013	4,387	8,400		20
21	Clerical & General Office Expenses	37,274	3,659	9,688	50,621		50,621	57,400	108,021		21
22	Employee Benefits & Payroll Taxes			183,106	183,106		183,106	25,483	208,589		22
23	Inservice Training & Education							148	148		23
24	Travel and Seminar							3	3		24
25	Other Admin. Staff Transportation			5,901	5,901		5,901	4,501	10,402		25
26	Insurance-Prop.Liab.Malpractice			2,281	2,281		2,281	1,129	3,410		26
27	Other (specify):* <u>Home Office Ben. Allocation</u>										27
28	TOTAL General Administration	78,941	3,659	523,021	605,621		605,621	(125,259)	480,362		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,849,154	359,254	1,213,907	3,422,315		3,422,315	(120,997)	3,301,318		29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			22,026	22,026		22,026	26,982	49,008		30
31	Amortization of Pre-Op. & Org.							4,098	4,098		31
32	Interest							272,372	272,372		32
33	Real Estate Taxes							46,836	46,836		33
34	Rent-Facility & Grounds			461,707	461,707		461,707	(461,707)			34
35	Rent-Equipment & Vehicles			47,176	47,176		47,176	1,300	48,476		35
36	Other (specify):*										36
37	TOTAL Ownership			530,909	530,909		530,909	(110,119)	420,790		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		19,230		19,230		19,230		19,230		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			175,208	175,208		175,208		175,208		42
43	Other (specify):* Miscellaneous	10,945	17	104,159	115,121		115,121	(115,121)			43
44	TOTAL Special Cost Centers	10,945	19,247	279,367	309,559		309,559	(115,121)	194,438		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,860,099	378,501	2,024,183	4,262,783		4,262,783	(346,237)	3,916,546		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				4
5	Telephone, TV & Radio in Resident Rooms	(6,927)	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	(2,112)	30		9
10	Interest and Other Investment Income	(2,108)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3)	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	(56,057)	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	(40,000)	43		24
25	Fund Raising, Advertising and Promotional	474	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	(91,598)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (198,331)		\$	30

BHF USE ONLY							
48		49		50		51	52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(147,906)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (147,906)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (346,237)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

South Elgin Rehabilitation & Health Care Center

ID# 0053140

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (3,633)	43	1
2	X-Rays-Part A	1,673	43	2
3	Offset Transportation Revenue	(1,004)	11	3
4	Offset Nursing Supplies Revenue	(3,117)	10	4
5	Offset Miscellaneous Office Supplies Revenue	(3,275)	21	5
6	Disallowed Special Events	297	43	6
7	Disallowed Marketing Expenses	(10,945)	43	7
8	Offset Escrow Refund-Insurance	(59,609)	26	8
9	Offset Escrow Refund-Equipment	(3,193)	21	9
10	Offset Escrow Refund-Maintenance	(8,792)	6	10
11				11
12				12
13				13
14				14
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38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(91,598)		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%	\$ 5,913	\$ 5,913	1
2	V	2 Food		Petersen Health Care Management, Inc.	100.00%	55	55	2
3	V	3 Housekeeping		Petersen Health Care Management, Inc.	100.00%	94	94	3
4	V	5 Utilities		Petersen Health Care Management, Inc.	100.00%	302	302	4
5	V	6 Maintenance		Petersen Health Care Management, Inc.	100.00%	2,319	2,319	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%	4,092	4,092	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	229,300	Petersen Health Care Management, Inc.	100.00%	72,113	(157,187)	11
12	V	19 Professional Services		Petersen Health Care Management, Inc.	100.00%	17,898	17,898	12
13	V							13
14	Total		\$ 229,300			\$ 102,786	\$ * (126,514)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	20 <u>Dues, Fees, Subs & Promotions</u>	\$	<u>Petersen Health Care Management, Inc.</u>	100.00%	\$ 4,387	\$	4,387	15
16	V	21 <u>Clerical and General Office</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	60,675		60,675	16
17	V	22 <u>Employee Benefits and Payroll Taxes</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	25,483		25,483	17
18	V	23 <u>Inservice Training & Education</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	148		148	18
19	V	24 <u>Travel and Seminar</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	3		3	19
20	V	25 <u>Other Admin. Staff Transport.</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	4,501		4,501	20
21	V	26 <u>Insurance-Prop./Liab./Malprac.</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	1,129		1,129	21
22	V	30 <u>Depreciation</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	14,350		14,350	22
23	V	31 <u>Amortization</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	130		130	23
24	V	32 <u>Interest</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	3,774		3,774	24
25	V	33 <u>Real Estate Taxes</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	447		447	25
26	V	35 <u>Rent-Equipment & Vehicles</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	1,300		1,300	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		\$			\$ 116,327	\$ *	116,327	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 Properties, LLC	100.00%	\$ 0	\$
16	V	2 Food		Petersen Health Properties, LLC	100.00%	0	
17	V	3 Housekeeping		Petersen Health Properties, LLC	100.00%	0	
18	V	4 Laundry		Petersen Health Properties, LLC	100.00%	0	
19	V	5 Utilities		Petersen Health Properties, LLC	100.00%	0	
20	V	6 Maintenance		Petersen Health Properties, LLC	100.00%	0	
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Properties, LLC	100.00%	0	
22	V	10 Nursing and Medical Records		Petersen Health Properties, LLC	100.00%	0	
23	V	15 Mgmt. Allocation of Benefits		Petersen Health Properties, LLC	100.00%	0	
24	V	17 Administrative	86,400	Petersen Health Properties, LLC	100.00%	0	(86,400)
25	V	19 Professional Services		Petersen Health Properties, LLC	100.00%	1,054	1,054
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Properties, LLC	100.00%	0	
27	V	21 Clerical and General Office		Petersen Health Properties, LLC	100.00%	0	
28	V	22 Employee Benefits & Payroll		Petersen Health Properties, LLC	100.00%	0	
29	V	23 Inservice Training & Education		Petersen Health Properties, LLC	100.00%	0	
30	V	24 Travel and Seminar		Petersen Health Properties, LLC	100.00%	0	
31	V	25 Other Admin. Staff Transport.		Petersen Health Properties, LLC	100.00%	0	
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Properties, LLC	100.00%	0	
33	V	30 Depreciation		Petersen Health Properties, LLC	100.00%	0	
34	V	31 Amortization		Petersen Health Properties, LLC	100.00%	0	
35	V	32 Interest		Petersen Health Properties, LLC	100.00%	56,675	56,675
36	V	33 Real Estate Taxes		Petersen Health Properties, LLC	100.00%	0	
37	V	34 Rent-Facility and Grounds		Petersen Health Properties, LLC	100.00%	0	
38	V	35 Rent-Equipment & Vehicles		Petersen Health Properties, LLC	100.00%	0	
39	Total		\$ 86,400			\$ 57,729	\$ * (28,671)

* 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	6 Maintenance	\$	South Elgin Land, LLC	100.00%	\$ 4,400	\$ 4,400
16	V	19 Professional Fees		South Elgin Land, LLC	100.00%	6,325	6,325
17	V	21 Equipment		South Elgin Land, LLC	100.00%	3,193	3,193
18	V	26 Insurance-Liability		South Elgin Land, LLC	100.00%	20,346	20,346
19	V	26 Insurance-MIP		South Elgin Land, LLC	100.00%	34,077	34,077
20	V	26 Insurance-Property		South Elgin Land, LLC	100.00%	5,186	5,186
21	V	30 Depreciation		South Elgin Land, LLC	100.00%	14,744	14,744
22	V	31 Amortization of Pre-Op. & Org.		South Elgin Land, LLC	100.00%	3,968	3,968
23	V	32 Interest	753	South Elgin Land, LLC	100.00%	214,784	214,031
24	V	33 Real Estate Taxes		South Elgin Land, LLC	100.00%	46,389	46,389
25	V	34 Rent-Facility and Grounds	461,707	South Elgin Land, LLC	100.00%		(461,707)
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 462,460			\$ 353,412	\$ * (109,048)

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

Facility Name & ID Number

South Elgin Rehabilitation & Health Care Center

0053140

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 & ID Number

South Elgin Rehabilitation & Health Care Center

0053140

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Mason Point	Sullivan				1
2			McLeansboro Rehab & Health Care Center	McLeansboro				2
3			Mt. Vernon Health Care Center	Mt. Vernon				3
4			Newman Rehab & Health Care Center	Newman				4
5			Nokomis Rehab & Health Care Center	Nokomis				5
6			North Aurora Care Center	North Aurora				6
7			Palm Terrace of Mattoon	Mattoon				7
8			Piper City Rehab & Living Center	Piper City				8
9			Pleasant View Rehab & Health Care Center	Morrison				9
10			Polo Rehabilitation & Health Care Center	Polo				10
11			Prairie City Rehab & Health Care Center	Prairie City				11
12			Robings Manor Nursing Home	Brighton				12
13			Rochelle Gardens	Rochelle				13
14			Rochelle Rehab & Health Care Center	Rochelle				14
15			Rock Falls Rehab & Health Care Center	Rock Falls				15
16			Arrow Wood Independent Living	Rock Falls				16
17			Roseville Rehab and Health Care Center	Roseville				17
18			Rosiclare Rehab & Health Care Center	Rosiclare				18
19			Royal Oaks Care Center	Kewanee				19
20			Sandwich Rehab & Health Care Center	Sandwich				20
21			Iron Wood Independent Living	Sandwich				21
22			Shawnee Rose Care Center	Harrisburg				22
23			Shelbyville Rehab & Health Care Center	Shelbyville				23
24			South Elgin Rehab & Health Care Center	South Elgin				24
25			Sullivan Health Care Center	Sullivan				25
26			Sunset Manor Nursing Home	Canton				26
27			Swansea Rehab & Health Care	Swansea				27
28			Timbercreek Rehab & Health Center	Pekin				28
29			Toulon Health Care Center	Toulon				29
30			Tuscola Health Care Center	Tuscola				30

Facility Name & ID Number

Bloomington Rehabilitation & Health Care Center

0047415

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Twin Lakes Rehab & Health Care Center	Paris				1
2			Vandalia Rehab & Health Care Center	Vandalia				2
3			Watseka Health Care Center	Watseka				3
4			Westside Rehab & Care Center	West Frankfort				4
5			Whispering Oaks	Rosiclare				5
6			White Oak Rehab & Health Care Center	Mt. Vernon				6
7			Willow Rose Rehab & Health Care Center	Jerseyville				7
8			Sheldon Health Care Center	Sheldon				8
9			Tuscola Health Care Center	Tuscola				9
10			Effingham Health Care Center	Effingham				10
11			Collinsville Health Care Center	Collinsville				11
12			Ozark Rehab & Health Care Center	Osage Beach, MO				12
13			Tarkio Rehab & Health Care Center	Tarkio, MO				13
14			Shangri-la Rehab & Living Center	Blue Springs, MO				14
15			Prairie Rose Care Center	Pana				15
16			Illini Heritage Rehab & Health Center	Champaign				16
17			Courtyard Estates of Kewanee	Kewanee				17
18			Courtyard Estates of Bradford	Bradford				18
19			Courtyard Estates of Galva	Galva				19
20			Courtyard Estates of Walcott	Walcott				20
21			Courtyard Village of Kewanee	Kewanee				21
22			Lakewood Village	Charleston				22
23			Courtyard Estates of Monmouth	Monmouth				23
24			Riverview Estates	Havana				24
25			Simple Blessings	Casey				25
26			Courtyard Estates of Bushnell	Bushnell				26
27			Courtyard Estates of Canton	Canton				27
28			Legacy Estates of Monmouth	Monmouth				28
29			Courtyard Estates of Sullivan	Sullivan				29
30			Courtyard Estates of Peoria	Peoria				30

Facility Name & ID Number

Bloomington Rehabilitation & Health Care Center

0047415

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Cornerstone Health and Rehabilitation	Peoria				1
2			Rock River Gardens	Sterling				2
3			Sauk Valley Senior Living & Rehabilitation	Rock Falls				3
4			Courtyard Estates of Farmington	Farmington				4
5			Courtyard Estates of Knoxville	Knoxville				5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number South Elgin Rehabilitation & Health Care C # 0053140 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 South Elgin Rehabilitation & Health Care Center # 0053140 Report Period Beginning: 1/1/2018 Ending: 2/31/2018

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,411,762	75	\$ 342,871	\$ 393,211	24,347	\$ 5,913	1
2	2	Food	Resident Days	1,411,762	75	3,216	0	24,347	55	2
3	3	Housekeeping	Resident Days	1,411,762	75	5,441	2,652	24,347	94	3
4	5	Utilities	Resident Days	1,411,762	75	17,524	0	24,347	302	4
5	6	Maintenance	Resident Days	1,411,762	75	134,460	148,272	24,347	2,319	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,411,762	75	0	0	24,347	0	6
7	9	Medical Director	Resident Days	1,411,762	75	0	0	24,347	0	7
8	10	Nursing and Medical Records	Resident Days	1,411,762	75	237,275	1,454,984	24,347	4,092	8
9	10A	Therapy	Resident Days	1,411,762	75	0	0	24,347	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,411,762	75	0	0	24,347	0	10
11	17	Administrative	Resident Days	1,411,762	75	4,940,583	5,658,897	24,347	72,113	11
12	19	Professional Services	Resident Days	1,411,762	75	1,037,806	0	24,347	17,898	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,411,762	75	254,355	0	24,347	4,387	13
14	21	Clerical and General Office	Resident Days	1,411,762	75	3,518,216	3,764,024	24,347	60,675	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,411,762	75	1,477,639	0	24,347	25,483	15
16	23	Inservice Training & Education	Resident Days	1,411,762	75	8,601	0	24,347	148	16
17	24	Travel and Seminar	Resident Days	1,411,762	75	174	0	24,347	3	17
18	25	Other Admin. Staff Transport.	Resident Days	1,411,762	75	261,018	0	24,347	4,501	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,411,762	75	65,437	0	24,347	1,129	19
20	30	Depreciation	Resident Days	1,411,762	75	832,087	0	24,347	14,350	20
21	31	Amortization	Resident Days	1,411,762	75	7,528	0	24,347	130	21
22	32	Interest	Resident Days	1,411,762	75	218,814	0	24,347	3,774	22
23	33	Real Estate Taxes	Resident Days	1,411,762	75	25,901	0	24,347	447	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,411,762	75	75,380	0	24,347	1,300	24
25	TOTALS					\$ 13,464,326	\$ 11,422,040		\$ 219,113	25

Facility Name & ID Number South Elgin Rehabilitation & Health Care Center # 0053140 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 Properties, 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	57,169	3	\$	24,347	\$	1
2	2	Food	Resident Days	57,169	3		24,347		2
3	3	Housekeeping	Resident Days	57,169	3		24,347		3
4	4	Laundry	Resident Days	57,169	3		24,347		4
5	5	Utilities	Resident Days	57,169	3		24,347		5
6	6	Maintenance	Resident Days	57,169	3		24,347		6
7	7	Mgmt. Allocation of Benefits	Resident Days	57,169	3		24,347		7
8	10	Nursing and Medical Records	Resident Days	57,169	3		24,347		8
9	15	Mgmt. Allocation of Benefits	Resident Days	57,169	3		24,347		9
10	17	Administrative	Resident Days	57,169	3		24,347		10
11	19	Professional Services	Resident Days	57,169	3	2,475	24,347	1,054	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	57,169	3		24,347		12
13	21	Clerical and General Office	Resident Days	57,169	3		24,347		13
14	22	Employee Benefits & Payroll	Resident Days	57,169	3		24,347		14
15	23	Inservice Training & Education	Resident Days	57,169	3		24,347		15
16	24	Travel and Seminar	Resident Days	57,169	3		24,347		16
17	25	Other Admin. Staff Transport.	Resident Days	57,169	3		24,347		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	57,169	3		24,347		18
19	30	Depreciation	Resident Days	57,169	3		24,347		19
20	31	Amortization	Resident Days	57,169	3		24,347		20
21	32	Interest	Resident Days	57,169	3	133,077	24,347	56,675	21
22	33	Real Estate Taxes	Resident Days	57,169	3		24,347		22
23	34	Rent-Facility and Grounds	Resident Days	57,169	3		24,347		23
24	35	Rent-Equipment & Vehicles	Resident Days	57,169	3		24,347		24
25	TOTALS					\$ 135,552	\$	\$ 57,729	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			
A. Directly Facility Related																		
Long-Term																		
1	Busey Bank		X	Mortgage	Varies	1/1/2015	5,499,260	\$ 5,205,312	12/31/2044	Varies	\$ 214,784	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6												6						
7												7						
8												8						
9	TOTAL Facility Related						\$ 5,499,260	\$ 5,205,312			\$ 214,784	9						
B. Non-Facility Related*																		
10								Interest Income Offset			(2,861)	10						
11								Home Office Allocation-PHP			56,675	11						
12								Home Office Allocation-PHCM			3,774	12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ 57,588	14						
15	TOTALS (line 9+line14)						\$ 5,499,260	\$ 5,205,312			\$ 272,372	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 34,077 Line # 26

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

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

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME South Elgin Rehabilitation & Health Care Center COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0053140

CONTACT PERSON REGARDING THIS REPORT MIKE KOCHER

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

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D) <u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to Nursing Home</u>
1. <u>06-34-226-014</u>	<u>Long-Term Care Facility</u>	\$ <u>47,924.58</u>	\$ <u>47,924.58</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>47,924.58</u></u>	\$ <u><u>47,924.58</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 15,169 B. General Construction Type: Exterior Brick Frame Wood 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: 169,005 2. Number of Years Over Which it is Being Amortized: 5

3. Current Period Amortization: 4,098 4. Dates Incurred: 2014-2015

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, and a final column for row numbers. Row 1: Facility, 131,116, 2005, \$ 467,500, 1. Row 2: (blank), (blank), (blank), (blank), 2. Row 3: TOTALS, 131,116, (blank), \$ 467,500, 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		2005	1970	\$ ***	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Wheelchair		2006	15,515		25	621	621	7,762	9
10	Backflow Prevention		2006	14,325		25	573	573	7,163	10
11	Walls		2006	3,550		25	142	142	1,775	11
12	7 Rooms-Floor Replacement, Painting, Wallpaper, Trim Labor		2007	10,400		20	520	520	5,980	12
13	7 Rooms-Floor Tile, Sink, Supplies, Paint, Wallpaper		2007	5,100		20	255	255	2,850	13
14	Fire Sprinkler System Repair		2008	2,580		15	172	172	1,806	14
15	Dry Pipe Valve Accelerator Replacement		2008	8,436		15	562	562	5,901	15
16	Sprinkler System Repairs		2008	5,156		15	344	344	3,612	16
17	Water Line Repairs		2008	6,969		15	464	464	4,872	17
18	Sprinkler System Replacement		2009	27,836		20	1,392	1,392	13,224	18
19	Pendant Sprinkler System		2010	5,462		7			5,462	19
20	Water Heater		2011	5,120		7	362	362	5,120	20
21	Air Conditioner		2012	3,046		15	204	204	1,326	21
22	Water Heater		2012	11,870		7	1,696	1,696	11,024	22
23	Sewer Line Repair		2013	2,816		7	402	402	2,211	23
24	Fire Sprinkler System Repair		2013	22,855		15	1,524	1,524	8,382	24
25	Paving in front of building		2013	3,960		15	264	264	1,452	25
26	Alarm System Replacement		2013	7,256		7	1,036	1,036	5,698	26
27	Grease Interceptor		2014	10,500		15	700	700	3,150	27
28	Water Heater		2014	4,981		7	712	712	3,204	28
29										29
30	Land Improvements Booked									30
31	Building Booked									31
32	Building Improvement Booked									32
33										33
34	2018-Home Office Allocation-Building Improvements									34
35	2018-Home Office Allocation-Land Improvements									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	2	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	Steel Pipe Repair	2015	\$ 9,510	\$	7	\$ 1,359	\$ 1,359	\$ 4,756	37
38	Water Heater	2015	4,020		7	574	574	2,009	38
39	Plumbing Repair	2016	4,225		7	604	604	1,510	39
40	Stonehenge Stone	2016	20,394		15	1,360	1,360	3,400	40
41	Retaining Wall	2016	21,122		15	1,408	1,408	3,520	41
42	Entry and Patio Door Replacement	2016	5,263		7	752	752	1,880	42
43	Water Heater	2016	6,675		7	954	954	2,385	43
44	Roof Replacement	2017	17,230		25	690	690	1,035	44
45	Air Compressor	2017	3,700		7	528	528	792	45
46	Water Pipe Repair	2017	12,000		7	1,714	1,714	2,571	46
47	Sprinkler Repair	2018	3,819		7	273	273	273	47
48	Plumbing Repair	2018	2,620		7	187	187	187	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	Building Improvement Booked			23,728			(23,728)		63
64									64
65	2018-Home Office Allocation-Building Improvements		11,452			275	275		65
66	2018-Home Office Allocation-Land Improvements		1,149			73	73		66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 300,912	\$ 23,728		\$ 22,696	\$ (1,032)	\$ 126,292	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	\$ 101,238	\$ 12,255	\$ 11,848	\$ (407)	5-10 yrs.	\$ 49,330	71
72	Current Year Purchases	6,474	787	462	(325)	7 yrs.	462	72
73	Fully Depreciated Assets	158,625					158,625	73
74	Home Office Allocation			14,002	14,002			74
75	TOTALS	\$ 266,337	\$ 13,042	\$ 26,312	\$ 13,270		\$ 208,417	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,034,749	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 36,770	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 49,008	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 12,238	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 334,709	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

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

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: \$ 48,476 Description: See Attached Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17					17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

**South Elgin Rehabilitation & Health Care Center
0053140**

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

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$ 42,366
Dishwasher	701
Copier	4,109
Home Office Allocation	1,300
	<u>48,476</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	\$	12,725	\$ 190,882	\$	12,725	\$ 190,882	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,271	19,064		1,271	19,064	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		17,988	263,440		17,988	263,440	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				19,230		19,230	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			\$	31,984	\$ 473,386	\$ 19,230	31,984	\$ 492,616	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 South Elgin Rehabilitation & Health Care Center# 0053140Report Period Beginning: 1/1/2018Ending: 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*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (1,585,588)	\$ (1,585,588)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>293,042</u>)	5,865,721	5,865,721	3
4	Supply Inventory (priced at <u>Cost</u>)	12,521	12,521	4
5	Short-Term Investments			5
6	Prepaid Insurance	40,423	59,412	6
7	Other Prepaid Expenses		36,101	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,333,077	\$ 4,388,167	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		467,500	13
14	Buildings, at Historical Cost		11,452	14
15	Leasehold Improvements, at Historical Cost	102,539	289,460	15
16	Equipment, at Historical Cost	82,028	266,337	16
17	Accumulated Depreciation (book methods)	(66,514)	(334,709)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		109,129	19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		259,020	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Intercompany Loans</u>		31,442	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 118,053	\$ 1,099,631	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,451,130	\$ 5,487,798	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,099,505	\$ 1,102,125	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	100,642	100,642	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,483	1,483	31
32	Accrued Real Estate Taxes(Sch.IX-B)		49,368	32
33	Accrued Interest Payable		17,741	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	530,808	530,808	36
37	<u>Accrued Management Fees</u>	438,820	438,820	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,171,258	\$ 2,240,987	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,205,312	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Intercompany Loans</u>	43,019	43,019	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 43,019	\$ 5,248,331	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,214,277	\$ 7,489,318	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,236,853	\$ (2,001,520)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,451,130	\$ 5,487,798	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,838,302	1
2	Restatements (describe):		2
3	Rounding	(3)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,838,299	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	398,554	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)	\$ 398,554	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)	\$ 2,236,853	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number South Elgin Rehabilitation & Health Care Center # 0053140 Report Period Beginning: 1/1/2018Ending: 12/31/2018**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.****Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,040,810	1
2	Discounts and Allowances for all Levels	(243,553)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,797,257	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	750,374	6
7	Oxygen	899	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 751,273	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		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	30,413	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	5,146	20
21	Other Medical Services	(4,171)	21
22	Laundry	321	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 31,709	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,108	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,108	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Transportation Revenue</u>	1,004	28
28a	<u>Miscellaneous Revenue</u>	77,986	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 78,990	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,661,337	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	639,999	31
32	Health Care	2,176,695	32
33	General Administration	605,621	33
B. Capital Expense			
34	Ownership	530,909	34
C. Ancillary Expense			
35	Special Cost Centers	134,351	35
36	Provider Participation Fee	175,208	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,262,783	40
41	Income before Income Taxes (line 30 minus line 40)**	398,554	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 398,554	43
III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 3,569,008	44
45	Private Pay - Net Inpatient Revenue	153,425	45
46	Medicare - Net Inpatient Revenue	69,318	46
47	Other-(specify) <u>Insurance Net Inpatient Revenue</u>	5,506	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,797,257	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 **South Elgin Rehabilitation & Health Care Center**

0053140

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	1,638	\$ 62,210	\$ 37.98	1
2	Assistant Director of Nursing	1,163	44,464	35.83	2
3	Registered Nurses	12,804	411,296	31.10	3
4	Licensed Practical Nurses	8,665	244,272	27.68	4
5	CNAs & Orderlies	38,190	495,633	12.62	5
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides	425	6,382	15.02	8
9	Activity Director	1,397	18,507	13.25	9
10	Activity Assistants	1,688	14,366	8.51	10
11	Social Service Workers	2,080	46,935	22.56	11
12	Dietician				12
13	Food Service Supervisor	2,881	42,357	14.70	13
14	Head Cook				14
15	Cook Helpers/Assistants	11,860	143,299	11.46	15
16	Dishwashers				16
17	Maintenance Workers	1,898	36,009	18.97	17
18	Housekeepers	11,365	119,508	10.14	18
19	Laundry	64	649	10.14	19
20	Administrator	2,011	72,113	35.86	20
21	Assistant Administrator	2,080	41,667	20.03	21
22	Other Administrative				22
23	Office Manager	2,080	37,274	17.92	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>	3,186	95,271	29.90	33
34	TOTAL (lines 1 - 33)	105,475	\$ 1,932,212 *	\$ 17.85	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly \$ 671	L1, C3	35
36	Medical Director	Monthly 11,500	L9,C3	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 8,894	L10, C3	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant	6 324	L10, C3	42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	6 \$ 21,389		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	99 \$ 3,379	L10, C3	50
51	Licensed Practical Nurses			51
52	Certified Nurse Assistants/Aides	3,297 105,202	L10, C3	52
53	TOTAL (lines 50 - 52)	3,396 \$ 108,581		53

South Elgin Rehabilitation & Health Care Center

0053140

Period Beginning 1/1/2018

Period End 12/31/2018

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	1,866	1,866	67,872	36.37
Transportation	819	819	16,454	20.09
Marketing	501	501	10,945	21.85
TOTAL	<u>3,186</u>	<u>3,186</u>	<u>95,271</u>	

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Susan Held	Administrator	0	\$ 31,776	Workers' Compensation Insurance	\$ 23,789	IDPH License Fee	\$ 1,990	
Steve Bennett	Administrator	0	40,337	Unemployment Compensation Insurance	11,161	Advertising: Employee Recruitment		
Michael Wickstrom	Asst. Admin.	0	41,667	FICA Taxes	139,780	Health Care Worker Background Check		
				Employee Health Insurance	2,642	(Indicate # of checks performed <u>23</u>)	690	
				Employee Meals		Patient Background Checks	267	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	1,066	
				Employee Relations	3,588	Home Office Allocation	4,387	
				Home Office Allocation	25,483			
				Employee Retirement	2,146			
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 113,780					
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
Description			Amount	\$ 208,589			\$ 8,400	
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 315,700				Less: Public Relations Expense ()	
							Non-allowable advertising ()	
							Yellow page advertising ()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 315,700					
(Attach a copy of any management service agreement)								
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
Ability Network	Computer Services		\$ 1,073				Out-of-State Travel	\$
Comcast Cable	Computer Services		1,156					
Fifth Third Bank	Legal Fees		57				In-State Travel	
Bank of America	Legal Fees		46	N/A				
							Seminar Expense	
							Home Office Allocation	3
							Entertainment Expense ()	
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			TOTAL	
(For legal fee disclosure, see page 39 of instructions)			\$ 2,332	\$			\$ 3	

* Attach copy of IMRF notifications

**See instructions.

South Elgin Rehabilitation & Health Care Center

0053140

Period Beginning

1/1/2018

Period End

12/31/2018

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		2,332

Home Office Allocation

Duane Morris	Legal	2447
Sedgwick CMS	Legal	217
SB2	Legal	604
Miscellaneous	Legal	180
Christoper P. Ryan	Legal	191
Saul Ewing Arnstein & Lehr	Legal	857
Healthcare Resources International	Legal	128
Winston & Strawn	Legal	2062
Lexis Nexis	Legal	9
Pretzel & Stouffer	Legal	30
CIBC	Legal	250
CliftonLarsonAllen	Accounting	1251
Ginoli & Co.	Accounting	1498
Duane Morris	Accounting	73
Getzler Henrich & Associates	Accounting	961
Kemper Consulting	Accounting	73
Baker Tilly Virchow Krause	Accounting	506
CIBC	Accounting	6075
Miscellaneous	Computer Services	133
Change Healthcare	Computer Services	4
TR Professional	Computer Services	13
Matrix Care	Computer Services	1405
Ability Network	Computer Services	2225
Stratus Networks	Computer Services	544
Kemper Technology	Computer Services	625
AT&T	Computer Services	7
Ungerboeck Software	Computer Services	449
CIAN	Computer Services	195
Comcast	Computer Services	48
CCH	Computer Services	18
Charter Communications	Computer Services	33
Allscripts	Computer Services	632
ATS	Computer Services	294
Citrix Systems	Computer Services	103
Optimizer	Other Prof Fees	57
Sedgwick CLMS	Other Prof Fees	198
David Budde	Other Prof Fees	56
Sargent Consulting	Other Prof Fees	156
Alix Partners	Other Prof Fees	590
Getzler Henrich & Associates	Other Prof Fees	80

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

27,609

**South Elgin Rehabilitation & Health Care Center
0053140**

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

Schedule 14A

25. Administrative and Staff Transportation

Gas	\$	1,974
Auto Repairs		1,483
Mileage-Travel		2,519
Travel-Hotels		(75)
Home Office Allocation		<u>4,501</u>
		<u><u>10,402</u></u>

