

		FOR BHF USE					

LL1

**2013**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2013)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p><b>I. IDPH License ID Number:</b> <u>0047423</u></p> <p><b>Facility Name:</b> <u>Cisne Rehab &amp; Hlth Care Ctr</u></p> <p><b>Address:</b> <u>107 N Watkins Bx 370</u> <u>Cisne</u> <u>62823</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>Wayne</u></p> <p><b>Telephone Number:</b> <u>(618) 673-2177</u> <b>Fax #</b> <u>(618) 673-2309</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>10/01/2005</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT  <input type="checkbox"/> Charitable Corp.  <input type="checkbox"/> Trust            IRS Exemption Code _____         </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY  <input type="checkbox"/> Individual  <input type="checkbox"/> Partnership  <input type="checkbox"/> Corporation  <input type="checkbox"/> "Sub-S" Corp.  <input checked="" type="checkbox"/> Limited Liability Co.  <input type="checkbox"/> Trust  <input type="checkbox"/> Other _____         </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL  <input type="checkbox"/> State  <input type="checkbox"/> County  <input type="checkbox"/> Other _____         </td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Mike Kocher</u> <b>Telephone Number:</b> <u>(309) 689-5850</u>  <b>Email Address:</b> _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2013</u> to <u>12/31/2013</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 5px; vertical-align: top;">Officer or Administrator of Provider</td> <td style="padding: 5px;">           (Signed) _____ (Date) _____            (Type or Print Name) <u>Mark B. Petersen</u>            (Title) <u>Chief Executive Officer</u> </td> </tr> <tr> <td style="width:20%; padding: 5px; vertical-align: top;">Paid Preparer</td> <td style="padding: 5px;">           (Signed) _____ (Date) _____            (Print Name and Title) _____            (Firm Name &amp; Address) _____            (Telephone) <u>( )</u> Fax # <u>( )</u> </td> </tr> </table> <p align="center"> <b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>  <b>201 S. Grand Avenue East</b>  <b>Springfield, IL 62763-0001</b> Phone # (217) 782-1630     </p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____ (Type or Print Name) <u>Mark B. Petersen</u> (Title) <u>Chief Executive Officer</u>	Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>( )</u> Fax # <u>( )</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Date) _____ (Type or Print Name) <u>Mark B. Petersen</u> (Title) <u>Chief Executive Officer</u>							
Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>( )</u> Fax # <u>( )</u>							

Facility Name & ID Number Cisne Rehab & Hlth Care Ctr

# 0047423 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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	11	Skilled (SNF)	11	4,015	1
2		Skilled Pediatric (SNF/PED)			2
3	24	Intermediate (ICF)	24	8,760	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	35	TOTALS	35	12,775	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			1,640	1,640	8
9	SNF/PED					9
10	ICF	7,113	1,943	1	9,057	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,113	1,943	1,641	10,697	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.73%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

Meals on Wheels

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES  NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES  NO

I. On what date did you start providing long term care at this location?  
Date started 10/1/2005

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 10/1/2005 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 11 and days of care provided 1,640

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2013 Fiscal Year: 12/31/2013

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

Facility Name &amp; ID Number

Cisne Rehab &amp; Hlth Care Ctr

# 0047423

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

**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	94,490	4,865		99,355		99,355	2,108	101,463		1
2	Food Purchase		60,279		60,279		60,279	(4,229)	56,050		2
3	Housekeeping	34,998	14,475		49,473		49,473	21	49,494		3
4	Laundry	18,117	4,672		22,789		22,789		22,789		4
5	Heat and Other Utilities			25,792	25,792		25,792	160	25,952		5
6	Maintenance	25,699	16,986	16,704	59,389		59,389	1,033	60,422		6
7	Other (specify):* Home Off. Ben. All.							119	119		7
8	<b>TOTAL General Services</b>	173,304	101,277	42,496	317,077		317,077	(788)	316,289		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			8,400	8,400		8,400		8,400		9
10	Nursing and Medical Records	533,222	42,299	2,614	578,135		578,135	(1,434)	576,701		10
10a	Therapy			197,124	197,124		197,124		197,124		10a
11	Activities	30,712	35	175	30,922		30,922	(12,400)	18,522		11
12	Social Services	23,224			23,224		23,224		23,224		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.										15
16	<b>TOTAL Health Care and Programs</b>	587,158	42,334	208,313	837,805		837,805	(13,834)	823,971		16
	<b>C. General Administration</b>										
17	Administrative			158,200	158,200		158,200	(112,200)	46,000		17
18	Directors Fees										18
19	Professional Services			10,562	10,562		10,562	55,938	66,500		19
20	Dues, Fees, Subscriptions & Promotions			4,802	4,802		4,802	727	5,529		20
21	Clerical & General Office Expenses	17,537	3,429	12,008	32,974		32,974	27,783	60,757		21
22	Employee Benefits & Payroll Taxes			121,536	121,536		121,536	(12)	121,524		22
23	Inservice Training & Education			450	450		450	42	492		23
24	Travel and Seminar							2	2		24
25	Other Admin. Staff Transportation			11,869	11,869		11,869	1,951	13,820		25
26	Insurance-Prop.Liab.Malpractice			13,479	13,479		13,479	377	13,856		26
27	Other (specify):* Home Off. Ben. All.							2,418	2,418		27
28	<b>TOTAL General Administration</b>	17,537	3,429	332,906	353,872		353,872	(22,974)	330,898		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	777,999	147,040	583,715	1,508,754		1,508,754	(37,596)	1,471,158		29

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

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

Facility Name &amp; ID Number

Cisne Rehab &amp; Hlth Care Ctr

#0047423

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			18,288	18,288		18,288	861	19,149			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,365	3,365		3,365	12,545	15,910			32
33	Real Estate Taxes			11,085	11,085		11,085	170	11,255			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			16,155	16,155		16,155	312	16,467			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			48,893	48,893		48,893	13,888	62,781			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		78,717		78,717		78,717		78,717			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			73,338	73,338		73,338		73,338			42
43	Other (specify):* Non-allowable Costs		612	58,270	58,882		58,882	(58,882)				43
44	<b>TOTAL Special Cost Centers</b>		79,329	131,608	210,937		210,937	(58,882)	152,055			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	777,999	226,369	764,216	1,768,584		1,768,584	(82,590)	1,685,994			45

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

**VI. ADJUSTMENT DETAIL**

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,554)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,957)	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	(989)	30		9
10	Interest and Other Investment Income	(8,937)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(64)	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	(7,152)	43		18
19	Entertainment				19
20	Contributions	(250)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(32,013)	43		24
25	Fund Raising, Advertising and Promotional	(2,144)	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 See Page 5A	(29,206)	Various		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (87,266)		\$	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)	4,676	Various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 4,676		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (82,590)		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.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

## Cisne Rehab &amp; Hlth Care Ctr

ID# 0047423

Report Period Beginning: 1/1/2013

Ending: 12/31/2013

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Disallowed Special Events	\$ 13	43	1
2	Offset Meals on Wheels Revenue	(2,720)	2	2
3	Offset Miscellaneous Office Supplies Revenue	(343)	21	3
4	Resident Flowers	(281)	43	4
5	Labs-Part A	(5,829)	43	5
6	X-Rays-Part A	(5,246)	43	6
7	Offset Transportation Revenue	(12,400)	11	7
8	Offset Miscellaneous Nursing Supplies Revenue	(1,441)	10	8
9	Disallowed Travel Air	(959)	43	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>		(29,206)	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Cisne Rehab & Hlth Care Ctr# 0047423

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	2,108	0	0	0	0	0	0	0	0	0	2,108	1
2	Food Purchase	(4,274)	45	0	0	0	0	0	0	0	0	0	(4,229)	2
3	Housekeeping	0	21	0	0	0	0	0	0	0	0	0	21	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	160	0	0	0	0	0	0	0	0	0	160	5
6	Maintenance	0	1,033	0	0	0	0	0	0	0	0	0	1,033	6
7	Other (specify):*	0	119	0	0	0	0	0	0	0	0	0	119	7
8	<b>TOTAL General Services</b>	<b>(4,274)</b>	<b>3,486</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(788)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(1,441)	7	0	0	0	0	0	0	0	0	0	(1,434)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(12,400)	0	0	0	0	0	0	0	0	0	0	(12,400)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>(13,841)</b>	<b>7</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(13,834)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(112,200)	0	0	0	0	0	0	0	0	0	(112,200)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	4,444	0	51,494	0	0	0	0	0	0	0	55,938	19
20	Fees, Subscriptions & Promotions	0	0	283	444	0	0	0	0	0	0	0	727	20
21	Clerical & General Office Expenses	(343)	0	26,123	2,003	0	0	0	0	0	0	0	27,783	21
22	Employee Benefits & Payroll Taxes	0	0	0	(12)	0	0	0	0	0	0	0	(12)	22
23	Inservice Training & Education	0	0	42	0	0	0	0	0	0	0	0	42	23
24	Travel and Seminar	0	0	2	0	0	0	0	0	0	0	0	2	24
25	Other Admin. Staff Transportation	0	0	1,951	0	0	0	0	0	0	0	0	1,951	25
26	Insurance-Prop.Liab.Malpractice	0	0	377	0	0	0	0	0	0	0	0	377	26
27	Other (specify):*	0	0	2,418	0	0	0	0	0	0	0	0	2,418	27
28	<b>TOTAL General Administration</b>	<b>(343)</b>	<b>(107,756)</b>	<b>31,196</b>	<b>53,929</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(22,974)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(18,458)</b>	<b>(104,263)</b>	<b>31,196</b>	<b>53,929</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(37,596)</b>	<b>29</b>



## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Cisne Rehab & Hlth Care Ctr# 0047423

Report Period Beginning:

1/1/2013 Ending:

12/31/2013

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	(989)	0	1,732	118	0	0	0	0	0	0	0	861	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(8,937)	0	2,881	18,601	0	0	0	0	0	0	0	12,545	32
33	Real Estate Taxes	0	0	170	0	0	0	0	0	0	0	0	170	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	312	0	0	0	0	0	0	0	0	312	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(9,926)</b>	<b>0</b>	<b>5,095</b>	<b>18,719</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>13,888</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(58,882)	0	0	0	0	0	0	0	0	0	0	(58,882)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(58,882)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(58,882)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(87,266)	(104,263)	36,291	72,648	0	0	0	0	0	0	0	(82,590)	45

**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:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 2,108	\$ 2,108	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	45	45	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	21	21	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	160	160	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	1,033	1,033	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	119	119	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	7	7	8
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		10
11	V	17 Administrative	158,200	Petersen Health Care, Inc.	100.00%	46,000	(112,200)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	4,444	4,444	12
13	V							13
14	Total		\$ 158,200			\$ 53,937	\$ * (104,263)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	20 Dues, Fees, Subs & Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 283	\$	283	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	26,123		26,123	16
17	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	42		42	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	2		2	18
19	V	25 Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	1,951		1,951	19
20	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	377		377	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	2,418		2,418	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	1,732		1,732	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	2,881		2,881	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	170		170	24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0			25
26	V	35 Rent-Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	312		312	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		\$			\$ 36,291	\$ *	36,291	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 Operations, LLC	100.00%	\$ 0	\$	15
16	V	2 Food		Petersen Health Operations, LLC	100.00%	0		16
17	V	3 Housekeeping		Petersen Health Operations, LLC	100.00%	0		17
18	V	4 Laundry		Petersen Health Operations, LLC	100.00%	0		18
19	V	5 Utilities		Petersen Health Operations, LLC	100.00%	0		19
20	V	6 Maintenance		Petersen Health Operations, LLC	100.00%	0		20
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	0		21
22	V	10 Nursing and Medical Records		Petersen Health Operations, LLC	100.00%	0		22
23	V	12 Social Services		Petersen Health Operations, LLC	100.00%	0		23
24	V	17 Administrative		Petersen Health Operations, LLC	100.00%	0		24
25	V	19 Professional Services		Petersen Health Operations, LLC	100.00%	51,494	51,494	25
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Operations, LLC	100.00%	444	444	26
27	V	21 Clerical and General Office		Petersen Health Operations, LLC	100.00%	2,003	2,003	27
28	V	22 Employee Benefits & Payroll		Petersen Health Operations, LLC	100.00%	(12)	(12)	28
29	V	23 Inservice Training & Education		Petersen Health Operations, LLC	100.00%	0		29
30	V	24 Travel and Seminar		Petersen Health Operations, LLC	100.00%	0		30
31	V	25 Other Admin. Staff Transport.		Petersen Health Operations, LLC	100.00%	0		31
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Operations, LLC	100.00%	0		32
33	V	27 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	0		33
34	V	30 Depreciation		Petersen Health Operations, LLC	100.00%	118	118	34
35	V	32 Interest		Petersen Health Operations, LLC	100.00%	18,601	18,601	35
36	V	33 Real Estate Taxes		Petersen Health Operations, LLC	100.00%	0		36
37	V	34 Rent-Facility and Grounds		Petersen Health Operations, LLC	100.00%	0		37
38	V	35 Rent-Equipment & Vehicles		Petersen Health Operations, LLC	100.00%	0		38
39	<b>Total</b>		\$			\$ 72,648	\$ *	72,648 39

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

Facility Name &amp; ID Number

Cisne Rehab &amp; Hlth Care Ctr

# 0047423

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

## 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 J	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 Restaurants,	Peoria	Restaurant	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Health Care	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Care	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	Mgmt/Bookkeeping	13
14			Decatur Rehab & Health Care Center	Decatur	Petersen Health Care	Peoria	Lessor	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Osage Beach,	Osage Beach, MO	Lessor	15
16			Eastview Terrace	Sullivan	Petersen West Frankf	West Frankfort	Lessor	16
17			El Paso Health Care Center	El Paso	Midwest Health Care,	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Poplar Bluff Health C	Poplar Bluff, MO	Lessor	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Roseville, LL	Roseville	Lessor	19
20			Flanagan Rehab & Health Care Center	Flanagan				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

Cisne Rehab &amp; Hlth Care Ctr

# 0047423

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

## 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			Orchard View Rehab & Health Care Center	Princeton				7
8			Palm Terrace of Mattoon	Mattoon				8
9			Piper City Rehab & Living Center	Piper City				9
10			Pleasant View Rehab & Health Care Center	Morrison				10
11			Polo Rehabilitation & Health Care Center	Polo				11
12			Prairie City Rehab & Health Care Center	Prairie City				12
13			Robings Manor Nursing Home	Brighton				13
14			Rochelle Gardens	Rochelle				14
15			Rochelle Rehab & Health Care Center	Rochelle				15
16			Rock Falls Rehab & Health Care Center	Rock Falls				16
17			Arrow Wood Independent Living	Rock Falls				17
18			Roseville Rehab and Health Care Center	Roseville				18
19			Rosiclare Rehab & Health Care Center	Rosiclare				19
20			Royal Oaks Care Center	Kewanee				20
21			Sandwich Rehab & Health Care Center	Sandwich				21
22			Iron Wood Independent Living	Sandwich				22
23			Shawnee Rose Care Center	Harrisburg				23
24			Shelbyville Rehab & Health Care Center	Shelbyville				24
25			South Elgin Rehab & Health Care Center	South Elgin				25
26			Sugar Creek Care Center	Watseka				26
27			Sullivan Health Care Center	Sullivan				27
28			Sunset Manor Nursing Home	Canton				28
29			Swansea Rehab & Health Care	Swansea				29
30			Timbercreek Rehab & Health Center	Pekin				30

Facility Name &amp; ID Number

Cisne Rehab &amp; Hlth Care Ctr

# 0047423

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

## 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			Toulon Health Care Center	Toulon				1
2			Tuscola Health Care Center	Tuscola				2
3			Twin Lakes Rehab & Health Care Center	Paris				3
4			Vandalia Rehab & Health Care Center	Vandalia				4
5			Watseka Health Care Center	Watseka				5
6			Westside Rehab & Care Center	West Frankfort				6
7			Whispering Oaks	Rosiclare				7
8			White Oak Rehab & Health Care Center	Mt. Vernon				8
9			Willow Rose Rehab & Health Care Center	Jerseyville				9
10			Sheldon Health Care Center	Sheldon				10
11			Tuscola Health Care Center	Tuscola				11
12			Effingham Health Care Center	Effingham				12
13			Collinsville Health Care Center	Collinsville				13
14			Ozark Rehab & Health Care Center	Osage Beach, MO				14
15			South Shore Health Care, LLC	Gary, IN				15
16			Cedargate Skilled Nursing Facility	Poplar Bluff, MO				16
17			Tarkio Rehab & Health Care Center	Tarkio, MO				17
18			Shangri-la Rehab & Living Center	Blue Springs, MO				18
19			Prairie Rose Care Center	Pana				19
20			Illini Heritage Rehab & Health Center	Champaign				20
21			Courtyard Estates of Kewanee	Kewanee				21
22			Courtyard Estates of Bradford	Bradford				22
23			Courtyard Estates of Galva	Galva				23
24			Courtyard Estates of Walcott	Walcott				24
25			Courtyard Village of Kewanee	Kewanee				25
26			Lakewood Village	Charleston				26
27			Courtyard Estates of Monmouth	Monmouth				27
28			Riverview Estates	Havana				28
29			Simple Blessings	Casey				29
30			Courtyard Estates of Bushnell	Bushnell				30

Facility Name & ID Number

Cisne Rehab & Hlth Care Ctr

# 0047423

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

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			Courtyard Estates of Canton	Canton				1
2			Legacy Estates of Monmouth	Monmouth				2
3			Courtyard Estates of Sullivan	Sullivan				3
4			Courtyard Estates of Peoria	Peoria				4
5			Cornerstone Health and Rehabilitation	Peoria				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 Cisne Rehab & Hlth Care Ctr # 0047423 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

## 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 Cisne Rehab & Hlth Care Ctr

# 0047423

Report Period Beginning:

1/1/2013

Ending: 2/31/2013

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, 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	1,560,986	75	\$ 307,592	\$ 295,212	10,697	\$ 2,108	1
2	2	Food	Resident Days	1,560,986	75	6,577	0	10,697	45	2
3	3	Housekeeping	Resident Days	1,560,986	75	3,057	0	10,697	21	3
4	4	Laundry	Resident Days	1,560,986	75	0	0	10,697	0	4
5	5	Utilities	Resident Days	1,560,986	75	23,338	0	10,697	160	5
6	6	Maintenance	Resident Days	1,560,986	75	150,672	97,358	10,697	1,033	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,560,986	75	17,394	0	10,697	119	7
8	10	Nursing and Medical Records	Resident Days	1,560,986	75	1,082	0	10,697	7	8
9	10A	Therapy	Resident Days	1,560,986	75	0	0	10,697	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,560,986	75	0	0	10,697	0	10
11	17	Administrative	Resident Days	1,560,986	75	4,578,456	4,578,456	10,697	46,000	11
12	19	Professional Services	Resident Days	1,560,986	75	648,504	0	10,697	4,444	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,560,986	75	41,231	0	10,697	283	13
14	21	Clerical and General Office	Resident Days	1,560,986	75	3,812,055	3,383,297	10,697	26,123	14
15	23	Inservice Training & Education	Resident Days	1,560,986	75	6,148	0	10,697	42	15
16	24	Travel and Seminar	Resident Days	1,560,986	75	313	0	10,697	2	16
17	25	Other Admin. Staff Transport.	Resident Days	1,560,986	75	284,745	0	10,697	1,951	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,560,986	75	54,993	0	10,697	377	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,560,986	75	352,851	0	10,697	2,418	19
20	30	Depreciation	Resident Days	1,560,986	75	252,711	0	10,697	1,732	20
21	32	Interest	Resident Days	1,560,986	75	420,365	0	10,697	2,881	21
22	33	Real Estate Taxes	Resident Days	1,560,986	75	24,742	0	10,697	170	22
23	34	Rent-Facility and Grounds	Resident Days	1,560,986	75	0	0	10,697	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,560,986	75	45,546	0	10,697	312	24
25	TOTALS					\$ 11,032,372	\$ 8,354,323		\$ 90,228	25

Facility Name & ID Number Cisne Rehab & Hlth Care Ctr

# 0047423

Report Period Beginning:

1/1/2013

Ending: 2/31/2013

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 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

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	408,598	21	\$	10,697	\$	1
2	2	Food	Resident Days	408,598	21		10,697		2
3	3	Housekeeping	Resident Days	408,598	21		10,697		3
4	4	Laundry	Resident Days	408,598	21		10,697		4
5	5	Utilities	Resident Days	408,598	21		10,697		5
6	6	Maintenance	Resident Days	408,598	21		10,697		6
7	7	Mgmt. Allocation of Benefits	Resident Days	408,598	21		10,697		7
8	10	Nursing and Medical Records	Resident Days	408,598	21		10,697		8
9	12	Social Services	Resident Days	408,598	21		10,697		9
10	17	Administrative	Resident Days	408,598	21		10,697		10
11	19	Professional Services	Resident Days	408,598	21	1,966,927	10,697	51,494	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	408,598	21	16,972	10,697	444	12
13	21	Clerical and General Office	Resident Days	408,598	21	76,520	10,697	2,003	13
14	22	Employee Benefits & Payroll	Resident Days	408,598	21	(465)	10,697	(12)	14
15	23	Inservice Training & Education	Resident Days	408,598	21		10,697		15
16	24	Travel and Seminar	Resident Days	408,598	21		10,697		16
17	25	Other Admin. Staff Transport.	Resident Days	408,598	21		10,697		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	408,598	21		10,697		18
19	27	Mgmt. Allocation of Benefits	Resident Days	408,598	21		10,697		19
20	30	Depreciation	Resident Days	408,598	21	4,500	10,697	118	20
21	32	Interest	Resident Days	408,598	21	710,525	10,697	18,601	21
22	33	Real Estate Taxes	Resident Days	408,598	21		10,697		22
23	34	Rent-Facility and Grounds	Resident Days	408,598	21		10,697		23
24	35	Rent-Equipment & Vehicles	Resident Days	408,598	21		10,697		24
25	TOTALS					\$ 2,774,979	\$	\$ 72,648	25

Facility Name & ID Number

Cisne Rehab & Hlth Care Ctr

# 0047423

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

**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		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	Bank of America		X	Mortgage	Varies	1/19/07	\$ 125,000	\$ 93,211	12/31/2014	Varies	\$ 3,365						
2																	
3																	
4																	
5																	
<b>Working Capital</b>																	
6																	
7																	
8																	
9	<b>TOTAL Facility Related</b>						\$ 125,000	\$ 93,211			\$ 3,365						
<b>B. Non-Facility Related*</b>																	
10																	
11											(8,937)						
12											2,881						
13											18,601						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ 12,545						
15	<b>TOTALS (line 9+line14)</b>						\$ 125,000	\$ 93,211			\$ 15,910						

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

\* 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.)

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)**

**B. Real Estate Taxes**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>			
1. Real Estate Tax accrual used on 2012 report.			\$ <b>11,100</b>	1	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2012		\$ <b>10,929</b>	2	
3. Under or (over) accrual (line 2 minus line 1).			\$ <b>(171)</b>	3	
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)			\$ <b>11,256</b>	4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$	5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.					
<b>TOTAL REFUND</b>	\$	For	Tax Year.		
			<b>Home Office Allocation</b>	<b>170</b>	
			\$	6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$ <b>11,255</b>	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2008	<u>9,923</u>	8		
	2009	<u>10,430</u>	9		
	2010	<u>10,938</u>	10		
	2011	<u>10,782</u>	11		
	2012	<u>10,929</u>	12		
<b>Accrual based on prior year tax bill.</b>					
				<b>FOR BHF USE ONLY</b>	
				13	FROM R. E. TAX STATEMENT FOR 2012 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
				15	LESS REFUND FROM LINE 6 \$ 15
				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

## 2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Cisne Rehab & Hlth Care Ctr COUNTY Wayne  
 FACILITY IDPH LICENSE NUMBER 0047423  
 CONTACT PERSON REGARDING THIS REPORT Mark Petersen  
 TELEPHONE (309) 691-8113 FAX #: (309) 691-8622

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

Enter the tax index number and real estate tax assessed for 2012 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 2012.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>03-50-065-006-00</u>	<u>Long-Term Care Facility</u>	\$ <u>99.88</u>	\$ <u>99.88</u>
2. <u>03-50-065-005</u>	<u>Long-Term Care Facility</u>	\$ <u>10,828.74</u>	\$ <u>10,828.74</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>10,928.62</u></u>	\$ <u><u>10,928.62</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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

**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: \_\_\_\_\_ B. General Construction Type: Exterior Brick Frame \_\_\_\_\_ 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: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
 3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Facility</u>	<u>75,359</u>	<u>2005</u>	<u>\$ 9,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>75,359</b>		<b>\$ 9,000</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	35	2005	1970	\$ 176,500	\$	25	\$ 7,060	\$ 7,060	\$ 60,010
5									
6									
7									
8									
Improvement Type**									
9	Original Land Improvements	2005		10,000		15	667	667	5,669
10	Waterline	2005		1,634		15	109	109	926
11	Carpet	2006		1,269		5			1,269
12	Gutter	2006		2,750		25	110	110	825
13	Sewer Line	2007		3,500		20	175	175	1,138
14	Condenser Unit	2009		5,018		7	717	717	3,226
15	Sprinkler System Repair	2011		3,799		7	542	542	1,355
16	Sewer Line Repair	2013		4,926		7	352	352	352
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30	Land Improvements Booked				1,009			(1,009)	
31	Building Booked				7,090			(7,090)	
32	Building Improvement Booked				1,897			(1,897)	
33									
34	2013-Home Office Allocation-Building Improvements			5,030			121	121	
35	2013-Home Office Allocation-Land Improvements			470			30	30	
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	<b>TOTAL (lines 4 thru 69)</b>	\$	214,896	\$	9,996	\$	9,883	\$	(113)	\$	74,770	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	\$ 17,152	\$ 2,450	\$ 1,714	\$ (736)	5-10 yrs.	\$ 7,793	71
72	Current Year Purchases	5,059	241	253	12	10 yrs.	253	72
73	Fully Depreciated Assets	39,452					39,452	73
74	Home Office Allocation			1,699	1,699			74
75	TOTALS	\$ 61,663	\$ 2,691	\$ 3,666	\$ 975		\$ 47,498	75

D. Vehicle Costs. (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	2010 Ford Van	2010	\$ 28,001	\$ 5,600	\$ 5,600	\$	5 yrs.	\$ 19,600	76
77										77
78										78
79										79
80	TOTALS			\$ 28,001	\$ 5,600	\$ 5,600	\$		\$ 19,600	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)	\$ 313,560	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 18,287	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 19,149	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 862	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 141,868	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.

Facility Name & ID Number Cisne Rehab & Hlth Care Ctr

# 0047423

Report Period Beginning: 1/1/2013

Ending: 12/31/2013

**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. \_\_\_\_\_ /2014 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2015 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2016 \$ \_\_\_\_\_

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: \$ 16,467 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	<u>N/A</u>				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.

**Cisne Rehab & Hlth Care Ctr**

**0047423**

**Period Beginning** 1/1/2013

**Period End** 12/31/2013

**Schedule 14A**

**XII. Rental Costs**

**B. Equipment**

**16. Description of rental amount for movable equipment**

Medical Equipment	\$	9,744
Dishwasher		1,205
Laundry Equipment		-
Copier		5,206
Home Office Allocation		312
		<u>16,467</u>

Facility Name & ID Number Cisne Rehab & Hlth Care Ctr # 0047423 Report Period Beginning: 1/1/2013 Ending: 12/31/2013  
**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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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		3	4
		1	2		
		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**

<b>COMPLETED</b>	
1. From this facility	
2. From other facilities (f)	
<b>DROP-OUTS</b>	
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	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)					
			Units	Cost												
1	Licensed Occupational Therapist	10A(3)	hrs	\$	5,260	\$ 78,905				5,260	\$ 78,905					1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2,638	39,564				2,638	39,564					2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	10A(3)	hrs		5,236	78,545				5,236	78,545					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							78,447	78,447					9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify): <u>Pharmacy Veterans</u>	39(2)								270	270					12
13	Other (specify): <u>Respiratory Therapy</u>	10A(3)								7	110			7	110	13
14	TOTAL			\$	13,141	\$ 197,124				\$ 78,717	13,141	\$ 275,841				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 Cisne Rehab & Hlth Care Ctr# 0047423Report Period Beginning: 1/1/2013

Ending:

12/31/2013

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2013

(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	\$ 1,488,568	\$ 1,488,568	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>38,333</u> )	275,246	275,246	3
4	Supply Inventory (priced at )	2,446	2,446	4
5	Short-Term Investments			5
6	Prepaid Insurance	12,575	12,575	6
7	Other Prepaid Expenses	2,498	2,498	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,781,333	\$ 1,781,333	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	24,134	9,000	13
14	Buildings, at Historical Cost	176,500	181,530	14
15	Leasehold Improvements, at Historical Cost	17,762	33,366	15
16	Equipment, at Historical Cost	89,664	89,664	16
17	Accumulated Depreciation (book methods)	(144,612)	(141,868)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 163,448	\$ 171,692	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,944,781	\$ 1,953,025	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 456,773	\$ 456,773	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	22,391	22,391	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,345	3,345	31
32	Accrued Real Estate Taxes(Sch.IX-B)	11,256	11,256	32
33	Accrued Interest Payable	254	254	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Payroll Withholdings</u>	24,515	24,515	36
37	<u>Accrued Management Fees</u>	115,506	115,506	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 634,040	\$ 634,040	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable	93,211	93,211	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>Due To Due From</u>	491,090	491,090	43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 584,301	\$ 584,301	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,218,341	\$ 1,218,341	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 726,440	\$ 734,684	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,944,781	\$ 1,953,025	48

\*(See instructions.)



XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ 610,417	1
2	Restatements (describe):		2
3	<b>Rounding</b>	(1)	3
4			4
5			5
6	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ 610,416	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	116,024	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	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ 116,024	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ 726,440	24 *

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

Facility Name & ID Number Cisne Rehab & Hlth Care Ctr# 0047423Report Period Beginning: 1/1/2013Ending: 12/31/2013

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	\$ 1,541,971	1
2	Discounts and Allowances for all Levels	(184,677)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 1,357,294	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	348,067	6
7	Oxygen	(104)	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 347,963	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	4,274	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	136,532	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	11,196	20
21	Other Medical Services	4,228	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 156,230	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	8,937	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 8,937	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Miscellaneous Revenue	1,784	28
28a	Transportation Revenue	12,400	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 14,184	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 1,884,608	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	317,077	31
32	Health Care	837,805	32
33	General Administration	353,872	33
<b>B. Capital Expense</b>			
34	Ownership	48,893	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	137,599	35
36	Provider Participation Fee	73,338	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 1,768,584	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	116,024	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 116,024	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 819,945	44
45	Private Pay - Net Inpatient Revenue	234,926	45
46	Medicare - Net Inpatient Revenue	303,052	46
47	Other-(specify) <u>Insurance Contractual Allowance</u>	(629)	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 1,357,294	49

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? \_\_\_\_\_ If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Cisne Rehab & Hlth Care Ctr

# 0047423

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,080	2,080	\$ 60,017	\$ 28.85	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,102	4,286	91,585	21.37	3
4	Licensed Practical Nurses	4,558	4,738	101,162	21.35	4
5	CNAs & Orderlies	23,309	23,839	238,204	9.99	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,872	2,081	24,841	11.94	9
10	Activity Assistants	34	34	411	12.09	10
11	Social Service Workers	1,906	1,991	23,224	11.66	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	26,654	12.81	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,530	6,649	67,836	10.20	15
16	Dishwashers					16
17	Maintenance Workers	1,910	2,004	25,699	12.82	17
18	Housekeepers	3,532	3,819	34,998	9.16	18
19	Laundry	1,817	1,918	18,117	9.45	19
20	Administrator	2,080	2,080	46,000	22.12	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,038	1,056	17,537	16.61	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 C: CPC	1,817	1,921	42,254	22.00	32
33	Other(specify) <u>Transportation</u>	489	496	5,460	11.01	33
34	TOTAL (lines 1 - 33)	59,154	61,072	\$ 823,999 *	\$ 13.49	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 8,400	L9, C3	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 2,245	L10, C3	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 10,645		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	N/A		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	
Pamela Mix-Bissey	Administrator	0	\$ 46,000	Workers' Compensation Insurance	\$ 19,919	IDPH License Fee	\$ 3,980	
				Unemployment Compensation Insurance	25,270	Advertising: Employee Recruitment		
				FICA Taxes	54,000	Health Care Worker Background Check		
				Employee Health Insurance	18,007	(Indicate # of checks performed )		
				Employee Meals		Patient Background Checks	72 716	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	0	
				Employee Relations	3,899	Miscellaneous Dues & Subscriptions	106	
				Employee Retirement	441	Home Office Allocation	727	
				Home Office Allocation	(12)			
TOTAL (agree to Schedule V, line 17, col. 1)						Less: Public Relations Expense	( )	
(List each licensed administrator separately.)			\$ 46,000			Non-allowable advertising	( )	
						Yellow page advertising	( )	
<b>B. Administrative - Other</b>								
Description			Amount	TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 158,200	\$ 121,524			\$ 5,529	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 158,200	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			Amount	
<b>C. Professional Services</b>				Line #				
Vendor/Payee	Type	Amount	Amount					
Wabash Independent Networks	Computer Services	\$ 685				Out-of-State Travel		
E-Health Data Solutions	Computer Services	6,763						
Gail and Rice	Accounting Fees	614				In-State Travel		
Consolidated Land Survey	Surveying Fees	2,500	N/A					
						Seminar Expense		
						Home Office Allocation		
						2		
						Entertainment Expense		
						( )		
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 10,562	\$			TOTAL	
							2	

\* Attach copy of IMRF notifications

\*\*See instructions.

Cisne Rehab & Hlth Care Ctr  
0047423  
Period Beginning  
Period End

1/1/2013  
12/31/2013

Schedule 21A

XIX. SUPPORT SCHEDULE  
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		10,562
<b>Home Office Allocation</b>		
SmithAmundsen	Legal	264
Cole, Schotz, Meisel	Legal	145
Black, Hedin, Ballard	Legal	13
Elias, Meginnes, Riffle & Seghetti	Legal	27
Miller, Hall, and Triggs	Legal	556
Evapar	Legal	107
Ginoli & Company	Accountants	1529
E-Health Data Solutions	Computer Services	1902
Miscellaneous	Computer Services	42
Odessian LLC	Computer Services	21
CCH	Computer Services	6
Lexis-Nexis	Computer Services	2
Ipanema Solutions	Computer Services	6
Macquarie Technology Services	Computer Services	38
Advanced Answers on Demand	Computer Services	1956
TeamViewer	Computer Services	6
Stratus Networks	Computer Services	158
Kemper Technology	Computer Services	122
AT&T	Computer Services	2
Medifax	Computer Services	18
Vision Share/Ability Network	Computer Services	268
Barracuda	Computer Services	48
CIAN	Computer Services	64
Comcast	Computer Services	14
Emdeon	Computer Services	22

Marotta Gund Budd & Dzera	Other Prof Fees	47749
David Budde	Other Prof Fees	12
Pharmacy Price Mangement	Other Prof Fees	246
All Scripts	Other Prof Fees	438
Registered Agent Solutions	Other Prof Fees	21
Healthink	Other Prof Fees	136
Total (agree to Schedule V, line 19, column 8)		<u><u>66,500</u></u>

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4	N/A											
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Cisne Rehab & Hlth Care Ctr# 0047423

Report Period Beginning:

1/1/2013

Ending:

12/31/2013**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? No  
If YES, give association name and amount. \_\_\_\_\_
- (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? 10 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 11,300 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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 73,338  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,554
- (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. \$ 12,400
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- 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? N/A
- g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Ginoli & Company
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? No  
Attach invoices and a summary of services for all architect and appraisal fees.