		FOR BHF USE					

LL1

DEPARTMI
FINANCIA

I. **IDPH License ID Number:** 0047548

Facility Name: Rosiclare Rehab & Hlth C Ctr

Address: Ferrell Road Box 220 (Number) Rosiclare (City)

County: Hardin

Telephone Number: (618) 285-3655 **Fax #** (618) 285-6667

HFS ID Number:

Date of Initial License for Current Owners: 10/01/2005

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOV
	Charitable Corp.		Individual		
	Trust		Partnership		
IRS Exemption Code			Corporation		
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Mike Kocher **Telephone Number:** (309) 689-5850
Email Address:

IMPORTANT NOTICE

THIS AGENCY IS REQUESTING DISCLOSURE C
THAT IS NECESSARY TO ACCOMPLISH THE ST
PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. I
OF THIS INFORMATION IS MANDATORY. FAII
ANY INFORMATION ON OR BEFORE THE DUE
RESULT IN CESSATION OF PROGRAM PAYME
HAS BEEN APPROVED BY THE FORMS MANA

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

62982
Zip Code

ERNMENTAL
State
County
Other

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to t
State of Illinois, for the period from 1/1/2013 to
and certify to the best of my knowledge and belief that the said c
are true, accurate and complete statements in accordance with
applicable instructions. Declaration of preparer (other than prov
is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any informati
in this cost report may be punishable by fine and/or imprisonme

Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) Mark B. Petersen (Title) Chief Executive Officer
Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) ( ) Fax #

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phon

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DISCLOSURE
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Y SERVICES

e # (217) 782-1630

Facility Name & ID Number Rosiclare Rehab & Hlth C Ctr

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period
1	62	Skilled (SNF)	62	22,630
2		Skilled Pediatric (SNF/PED)		
3		Intermediate (ICF)		
4		Intermediate/DD		
5		Sheltered Care (SC)		
6		ICF/DD 16 or Less		
7	62	TOTALS	62	22,630

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total
8	SNF	12,343	2,130	2,210	16,683
9	SNF/PED				
10	ICF				
11	ICF/DD				
12	SC				
13	DD 16 OR LESS				
14	TOTALS	12,343	2,130	2,210	16,683

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.72%

0047548 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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)

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 [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES [ ] NO [X]

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 [X] Date 10/1/2005 NO [ ]

K. Was the facility certified for Medicare during the reporting year?

YES [X] NO [ ] If YES, enter number of beds certified 62 and days of care provided 2,116

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

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

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

Facility Name & ID Number Rosiclare Rehab & Hlth C Ctr #

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

	Operating Expenses	Costs Per General Ledger			
		Salary/Wage	Supplies	Other	Total
	A. General Services	1	2	3	4
1	Dietary	101,806	8,709	3,472	113,987
2	Food Purchase		88,708		88,708
3	Housekeeping	74,719	14,770		89,489
4	Laundry	18,914	6,074		24,988
5	Heat and Other Utilities			57,492	57,492
6	Maintenance	25,104	14,859	15,098	55,061
7	Other (specify):* Home Off. Ben. All.				
8	**TOTAL General Services**	220,543	133,120	76,062	429,725
	B. Health Care and Programs				
9	Medical Director			4,800	4,800
10	Nursing and Medical Records	710,863	79,588	4,559	795,010
10a	Therapy		82	300,233	300,315
11	Activities	37,550	5	289	37,844
12	Social Services		51		51
13	CNA Training				
14	Program Transportation				
15	Other (specify):* Home Off. Ben. All.				
16	**TOTAL Health Care and Programs**	748,413	79,726	309,881	1,138,020
	C. General Administration				
17	Administrative			250,600	250,600
18	Directors Fees				
19	Professional Services			9,889	9,889
20	Dues, Fees, Subscriptions & Promotions			5,232	5,232
21	Clerical & General Office Expenses	31,598	2,052	159,289	192,939
22	Employee Benefits & Payroll Taxes			161,241	161,241
23	Inservice Training & Education			121	121
24	Travel and Seminar				
25	Other Admin. Staff Transportation			11,991	11,991
26	Insurance-Prop.Liab.Malpractice			23,089	23,089
27	Other (specify):* Home Off. Ben. All.				
28	**TOTAL General Administration**	31,598	2,052	621,452	655,102
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,000,554	214,898	1,007,395	2,222,847

***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 includ

Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	113,987	3,287	117,274			1
	88,708	(2,708)	86,000			2
	89,489	33	89,522			3
	24,988		24,988			4
	57,492	249	57,741			5
	55,061	1,610	56,671			6
		186	186			7
	429,725	2,657	432,382			8
	4,800		4,800			9
	795,010	12	795,022			10
	300,315		300,315			10a
	37,844	(16,839)	21,005			11
	51		51			12
						13
						14
						15
	1,138,020	(16,827)	1,121,193			16
	250,600	(173,736)	76,864			17
						18
	9,889	87,240	97,129			19
	5,232	1,134	6,366			20
	192,939	43,727	236,666			21
	161,241	(19)	161,222			22
	121	66	187			23
		3	3			24
	11,991	3,043	15,034			25
	23,089	588	23,677			26
		3,771	3,771			27
	655,102	(34,183)	620,919			28
	2,222,847	(48,353)	2,174,494			29

e a detailed explanation of each reclassification.

Facility Name & ID Number **Rosiclare Rehab & Hlth C Ctr**

V. COST CENTER EXPENSES (continued)

		Cost Per General Ledger			
	Capital Expense	**Salary/Wage**	**Supplies**	**Other**	**Total**
	D. Ownership	**1**	**2**	**3**	**4**
30	Depreciation			**62,073**	**62,073**
31	Amortization of Pre-Op. & Org.				
32	Interest			**94,281**	**94,281**
33	Real Estate Taxes			**5,584**	**5,584**
34	Rent-Facility & Grounds				
35	Rent-Equipment & Vehicles			**48,070**	**48,070**
36	Other (specify):*				
37	**TOTAL Ownership**			**210,008**	**210,008**
	Ancillary Expense				
	E. Special Cost Centers				
38	Medically Necessary Transportation				
39	Ancillary Service Centers		**83,097**		**83,097**
40	Barber and Beauty Shops				
41	Coffee and Gift Shops				
42	Provider Participation Fee			**123,514**	**123,514**
43	Other (specify):* **Non-allowable Costs**			**92,569**	**92,569**
44	**TOTAL Special Cost Centers**		**83,097**	**216,083**	**299,180**
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	**1,000,554**	**297,995**	**1,433,486**	**2,732,035**

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $100**

Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	62,073	3,730	65,803			30
						31
	94,281	22,181	116,462			32
	5,584	264	5,848			33
						34
	48,070	487	48,557			35
						36
	210,008	26,662	236,670			37
						38
	83,097		83,097			39
						40
						41
	123,514		123,514			42
	92,569	(92,569)				43
	299,180	(92,569)	206,611			44
	2,732,035	(114,260)	2,617,775			45

0.

Facility Name & ID Number Rosiclare Rehab & Hlth C Ctr **#** 0047548

VI. ADJUSTMENT DETAIL **A. The expenses indicated below are non-allowable and should**
In column 2 below, reference the line on which the particula

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY
1	Day Care	$		$
2	Other Care for Outpatients			
3	Governmental Sponsored Special Programs			
4	Non-Patient Meals	(2,778)	2	
5	Telephone, TV & Radio in Resident Rooms	(6,342)	43	
6	Rented Facility Space			
7	Sale of Supplies to Non-Patients			
8	Laundry for Non-Patients			
9	Non-Straightline Depreciation	845	30	
10	Interest and Other Investment Income	(11,323)	32	
11	Discounts, Allowances, Rebates & Refunds			
12	Non-Working Officer's or Owner's Salary			
13	Sales Tax	(125)	43	
14	Non-Care Related Interest			
15	Non-Care Related Owner's Transactions			
16	Personal Expenses (Including Transportation)			
17	Non-Care Related Fees			
18	Fines and Penalties	(19,568)	43	
19	Entertainment			
20	Contributions			
21	Owner or Key-Man Insurance			
22	Special Legal Fees & Legal Retainers			
23	Malpractice Insurance for Individuals			
24	Bad Debt	(48,094)	43	
25	Fund Raising, Advertising and Promotional	(1,390)	43	
26	Income Taxes and Illinois Personal Property Replacement Tax			
27	CNA Training for Non-Employees			
28	Yellow Page Advertising			
29	Other-Attach Schedule **See Page 5A**	(34,027)	Various	
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (122,802)		$

BHF USE ONLY									
48		49		50		51		52	

be adjusted out of Schedule V, pages 3 or 4 via column 7.
r cost was included. (See instructions.)

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*		**$**		31
32	Donated Goods-Attach Schedule*				32
33	Amortization of Organization & Pre-Operating Expense				33
34	Adjustments for Related Organization Costs (Schedule VII)		**8,542**	**Various**	34
35	Other- Attach Schedule				35
36	**SUBTOTAL (B): (sum of lines 31-35)**		**$ 8,542**		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**		**$ (114,260)**		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**	**$**		38
39						39
40	Gift and Coffee Shops		**X**			40
41	Barber and Beauty Shops		**X**			41
42	Laboratory and Radiology		**X**			42
43	Prescription Drugs		**X**			43
44						44
45	Other-Attach Schedule		**X**			45
46	Other-Attach Schedule		**X**			46
47	**TOTAL (C): (sum of lines 38-46)**			**$**		47

Rosiclare Rehab & Hlth C Ctr

ID# 0047548

Report Period Beginning: 1/1/2013

Ending: 12/31/2013

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs-Part A	$ (12,624)	43	1
2	X-Rays-Part A	(3,540)	43	2
3	Offset Transportation Revenue	(16,839)	11	3
4	Offset Miscellaneous Office Supplies Revenue	(138)	21	4
5	Disallowed Special Events	73	43	5
6	Disallowed Air Travel Expense	(959)	43	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
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	**Total**	(34,027)		49

Facility Name & ID Number **Rosiclare Rehab & Hlth C Ctr**

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
	A. General Services				
1	Dietary	0	3,287	0	0
2	Food Purchase	0	70	0	0
3	Housekeeping	0	33	0	0
4	Laundry	0	0	0	0
5	Heat and Other Utilities	0	249	0	0
6	Maintenance	0	1,610	0	0
7	Other (specify):*	0	186	0	0
8	**TOTAL General Services**	0	5,435	0	0
	B. Health Care and Programs				
9	Medical Director	0	0	0	0
10	Nursing and Medical Records	0	12	0	0
10a	Therapy	0	0	0	0
11	Activities	(16,839)	0	0	0
12	Social Services	0	0	0	0
13	CNA Training	0	0	0	0
14	Program Transportation	0	0	0	0
15	Other (specify):*	0	0	0	0
16	**TOTAL Health Care and Programs**	(16,839)	12	0	0
	C. General Administration				
17	Administrative	0	(173,736)	0	0
18	Directors Fees	0	0	0	0
19	Professional Services	0	6,931	0	80,309
20	Fees, Subscriptions & Promotions	0	0	441	693
21	Clerical & General Office Expenses	(138)	0	40,741	3,124
22	Employee Benefits & Payroll Taxes	0	0	0	(19)
23	Inservice Training & Education	0	0	66	0
24	Travel and Seminar	0	0	3	0
25	Other Admin. Staff Transportation	0	0	3,043	0
26	Insurance-Prop.Liab.Malpractice	0	0	588	0
27	Other (specify):*	0	0	3,771	0
28	**TOTAL General Administration**	(138)	(166,805)	48,653	84,107
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(16,977)	(161,358)	48,653	84,107

STATE OF ILLINOIS

0047548 Report Period Beginning: 1/1/2013 Ending:

PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
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0	0	0	0	0	0	0
0	0	0	0	0	0	0

Summary A
12/31/2013

SUMMARY TOTALS (to Sch V, col.7)	
3,287	1
70	2
33	3
0	4
249	5
1,610	6
186	7
5,435	8
0	9
12	10
0	10a
(16,839)	11
0	12
0	13
0	14
0	15
(16,827)	16
(173,736)	17
0	18
87,240	19
1,134	20
43,727	21
(19)	22
66	23
3	24
3,043	25
588	26
3,771	27
(34,183)	28
(45,575)	29

STATE OF ILLINOIS

Facility Name & ID Number **Rosiclare Rehab & Hlth C Ctr**

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE
	D. Ownership	**5 & 5A**	**6**	**6A**	**6B**
30	Depreciation	**(6,342)**	**0**	**2,701**	**184**
31	Amortization of Pre-Op. & Org.	**0**	**0**	**0**	**0**
32	Interest	**0**	**0**	**4,493**	**29,011**
33	Real Estate Taxes	**0**	**0**	**264**	**0**
34	Rent-Facility & Grounds	**0**	**0**	**0**	**0**
35	Rent-Equipment & Vehicles	**0**	**0**	**487**	**0**
36	Other (specify):*	**0**	**0**	**0**	**0**
37	**TOTAL Ownership**	**(6,342)**	**0**	**7,945**	**29,195**
	Ancillary Expense				
	E. Special Cost Centers				
38	Medically Necessary Transportation	**0**	**0**	**0**	**0**
39	Ancillary Service Centers	**0**	**0**	**0**	**0**
40	Barber and Beauty Shops	**0**	**0**	**0**	**0**
41	Coffee and Gift Shops	**0**	**0**	**0**	**0**
42	Provider Participation Fee	**0**	**0**	**0**	**0**
43	Other (specify):*	**(16,205)**	**0**	**0**	**0**
44	**TOTAL Special Cost Centers**	**(16,205)**	**0**	**0**	**0**
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	**(39,524)**	**(161,358)**	**56,598**	**113,302**

 # 0047548 Report Period Beginning: 1/1/2013 Ending:

PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
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0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0

Summary B
12/31/2013

SUMMARY TOTALS (to Sch V, col.7)	
(3,457)	30
0	31
33,504	32
264	33
0	34
487	35
0	36
30,798	37
0	38
0	39
0	40
0	41
0	42
(16,205)	43
(16,205)	44
(30,982)	45

Facility Name & ID Number Rosiclare Rehab & Hlth C Ctr

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defin

1 OWNERS		2 RELATED NURSI
Name	Ownership %	Name
Mark B. Petersen	100	See PG6 - Supp

B. Are any costs included in this report which are a result of transactions with related organizations? management fees, purchase of supplies, and so forth. [X] YES [ ]

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

1	Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Org Name of Related O
1	V	1	Dietary	$	Petersen Health Ca
2	V	2	Food		Petersen Health Ca
3	V	3	Housekeeping		Petersen Health Ca
4	V	4	Laundry		Petersen Health Ca
5	V	5	Utilities		Petersen Health Ca
6	V	6	Maintenance		Petersen Health Ca
7	V	7	Mgmt. Allocation of Benefits		Petersen Health Ca
8	V	10	Nursing and Medical Records		Petersen Health Ca
9	V	10A	Therapy		Petersen Health Ca
10	V	15	Mgmt. Allocation of Benefits		Petersen Health Ca
11	V	17	Administrative	250,600	Petersen Health Ca
12	V	19	Professional Services		Petersen Health Ca
13	V				
14	Total			$ 250,600	

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

ed in the instructions. Use Page 6-Supplemental as necessary.

NG HOMES		3 OTHER RELATED BUSINESS ENTITIES		
	City	Name	City	Type of Busine
		See PG6 - Supp		

This includes rent,
NO

accordance with

ganization	6	7	8 Difference:
rganization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
ıre, Inc.	100.00%	$ 3,287	$ 3,287
ıre, Inc.	100.00%	70	70
ıre, Inc.	100.00%	33	33
ıre, Inc.	100.00%	0	
ıre, Inc.	100.00%	249	249
ıre, Inc.	100.00%	1,610	1,610
ıre, Inc.	100.00%	186	186
ıre, Inc.	100.00%	12	12
ıre, Inc.	100.00%	0	
ıre, Inc.	100.00%	0	
ıre, Inc.	100.00%	76,864	(173,736)
ıre, Inc.	100.00%	6,931	6,931
		$ 89,242	$ * (161,358)

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Facility Name & ID Number Rosiclare Rehab & Hlth C Ctr

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? T
management fees, purchase of supplies, and so forth. [X] YES [ ]

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Org Name of Related O
15	V	20	Dues, Fees, Subs & Promotions	$	Petersen Health Care
16	V	21	Clerical and General Office		Petersen Health Care
17	V	23	Inservice Training & Education		Petersen Health Care
18	V	24	Travel and Seminar		Petersen Health Care
19	V	25	Other Admin. Staff Transport.		Petersen Health Care
20	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care
21	V	27	Mgmt. Allocation of Benefits		Petersen Health Care
22	V	30	Depreciation		Petersen Health Care
23	V	32	Interest		Petersen Health Care
24	V	33	Real Estate Taxes		Petersen Health Care
25	V	34	Rent-Facility and Grounds		Petersen Health Care
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care
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			$	

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

This includes rent,
NO

accordance with

ganization	6	7	8 Difference:
rganization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
, Inc.	100.00%	$ 441	$ 441
, Inc.	100.00%	40,741	40,741
, Inc.	100.00%	66	66
, Inc.	100.00%	3	3
, Inc.	100.00%	3,043	3,043
, Inc.	100.00%	588	588
, Inc.	100.00%	3,771	3,771
, Inc.	100.00%	2,701	2,701
, Inc.	100.00%	4,493	4,493
, Inc.	100.00%	264	264
, Inc.	100.00%	0	
, Inc.	100.00%	487	487
		$ 56,598	$ * 56,598

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Facility Name & ID Number Rosiclare Rehab & Hlth C Ctr

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? T
management fees, purchase of supplies, and so forth. [X] YES [ ]

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Or Name of Related O
15	V	1	Dietary	$	Petersen Health Oper
16	V	2	Food		Petersen Health Oper
17	V	3	Housekeeping		Petersen Health Oper
18	V	4	Laundry		Petersen Health Oper
19	V	5	Utilities		Petersen Health Oper
20	V	6	Maintenance		Petersen Health Oper
21	V	7	Mgmt. Allocation of Benefits		Petersen Health Oper
22	V	10	Nursing and Medical Records		Petersen Health Oper
23	V	12	Social Services		Petersen Health Oper
24	V	17	Administrative		Petersen Health Oper
25	V	19	Professional Services		Petersen Health Oper
26	V	20	Dues, Fees, Subs & Promotions		Petersen Health Oper
27	V	21	Clerical and General Office		Petersen Health Oper
28	V	22	Employee Benefits & Payroll		Petersen Health Oper
29	V	23	Inservice Training & Education		Petersen Health Oper
30	V	24	Travel and Seminar		Petersen Health Oper
31	V	25	Other Admin. Staff Transport.		Petersen Health Oper
32	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Oper
33	V	27	Mgmt. Allocation of Benefits		Petersen Health Oper
34	V	30	Depreciation		Petersen Health Oper
35	V	32	Interest		Petersen Health Oper
36	V	33	Real Estate Taxes		Petersen Health Oper
37	V	34	Rent-Facility and Grounds		Petersen Health Oper
38	V	35	Rent-Equipment & Vehicles		Petersen Health Oper
39	Total			$	

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

This includes rent,
NO

accordance with

ganization	6	7	8 Difference:
rganization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
rations, LLC	100.00%	$ 0	$
rations, LLC	100.00%	0	
rations, LLC	100.00%	0	
rations, LLC	100.00%	0	
rations, LLC	100.00%	0	
rations, LLC	100.00%	0	
rations, LLC	100.00%	0	
rations, LLC	100.00%	0	
rations, LLC	100.00%	0	
rations, LLC	100.00%	0	
rations, LLC	100.00%	80,309	80,309
rations, LLC	100.00%	693	693
rations, LLC	100.00%	3,124	3,124
rations, LLC	100.00%	(19)	(19)
rations, LLC	100.00%	0	
rations, LLC	100.00%	0	
rations, LLC	100.00%	0	
rations, LLC	100.00%	0	
rations, LLC	100.00%	0	
rations, LLC	100.00%	184	184
rations, LLC	100.00%	29,011	29,011
rations, LLC	100.00%	0	
rations, LLC	100.00%	0	
rations, LLC	100.00%	0	
		$ 113,302	$ * 113,302

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Facility Name & ID Number Rosiclare Rehab & Hlth C Ctr

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizat

	1 OWNERS		2 RELATED NU
	Name	**Ownership %**	**Name**
1			Aledo Health Care Center
2			Arcola Health Care Center
3			Aspen Rehab & Health Care
4			Batavia Rehab & Health Care Cent
5			Bement Health Care Center
6			Benton Rehab & Health Care Cent
7			Bloomington Rehab & Health Care
8			Casey Health Care Center
9			Charleston Rehab & Health Care C
10			Cisne Rehab & Health Care Center
11			Countryview Care Center of Macor
12			Countryview Terrace
13			Cumberland Rehab & Health Care
14			Decatur Rehab & Health Care Cen
15			Eastside Health & Rehabilitation C
16			Eastview Terrace
17			El Paso Health Care Center
18			Enfield Rehab & Health Care Cent
19			Farmer City Rehab & Health Care
20			Flanagan Rehab & Health Care Ce
21			Flora Gardens Care Center
22			Flora Health Care Center
23			Fondulac Rehab & Health Care Ce
24			Havana Health Care Center
25			Illini Heritage Rehab & Health Car
26			Jonesboro Rehab & Health Care C
27			Kewanee Care Home
28			LaHarpe Davier Health Care Cente
29			Lebanon Care Center
30			Marigold Rehab & Health Care Ce

tions (parties) as defined in the instructions.

JRSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
	City	Name	City	Type of Business
	Aledo	Petersen Companies, L	Peoria	Mgmt/Bookkeeping
	Arcola	Petersen Health Care I	Peoria	Mgmt/Bookkeeping
	Silvis	Petersen Health Care,	Peoria	Mgmt/Bookkeeping
ter	Batavia	Petersen Health Enterp	Peoria	Mgmt/Bookkeeping
	Bement	Petersen Health Opera	Peoria	Mgmt/Bookkeeping
er	Benton	Petersen Health Systen	Peoria	Mgmt/Bookkeeping
Center	Bloomington	Petersen Hotels LLC	Peoria	Hospitality
	Casey	Petersen Restaurants,	Peoria	Restaurant
Center	Charleston	Petersen Health Care I	Peoria	Mgmt/Bookkeeping
	Cisne	Petersen Health Care V	Peoria	Mgmt/Bookkeeping
mb	Macomb	Petersen Health Care V	Peoria	Mgmt/Bookkeeping
	Louisville	Petersen Health Care V	Sullivan	Lessor
Center	Greenup	Petersen Health Care V	Peoria	Mgmt/Bookkeeping
ter	Decatur	Petersen Health Care X	Peoria	Lessor
enter	Pittsfield	Petersen Osage Beach,	Osage Beach. MO	Lessor
	Sullivan	Petersen West Frankfo	West Frankfort	Lessor
	El Paso	Midwest Health Care,	Peoria	Mgmt/Bookkeeping
er	Enfield	Poplar Bluff Health Ca	Poplar Bluff, MO	Lessor
Center	Farmer City	Petersen Roseville, LL	Roseville	Lessor
nter	Flanagan			
	Flora			
	Flora			
nter	East Peoria			
	Havana			
re	Champaign			
enter	Jonesboro			
	Kewanee			
er	LaHarpe			
	Lebanon			
nter	Galesburg			

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Facility Name & ID Number Rosiclare Rehab & Hlth C Ctr

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizat

	1 OWNERS		2 RELATED NU
	Name	Ownership %	Name
1			Mason Point
2			McLeansboro Rehab & Health Car
3			Mt. Vernon Health Care Center
4			Newman Rehab & Health Care Cer
5			Nokomis Rehab & Health Care Cer
6			North Aurora Care Center
7			Orchard View Rehab & Health Ca
8			Palm Terrace of Mattoon
9			Piper City Rehab & Living Center
10			Pleasant View Rehab & Health Car
11			Polo Rehabilitation & Health Care
12			Prairie City Rehab & Health Care
13			Robings Manor Nursing Home
14			Rochelle Gardens
15			Rochelle Rehab & Health Care Cer
16			Rock Falls Rehab & Health Care C
17			Arrow Wood Independent Living
18			Roseville Rehab and Health Care C
19			Rosiclare Rehab & Health Care Ce
20			Royal Oaks Care Center
21			Sandwich Rehab & Health Care Ce
22			Iron Wood Independent Living
23			Shawnee Rose Care Center
24			Shelbyville Rehab & Health Care C
25			South Elgin Rehab & Health Care
26			Sugar Creek Care Center
27			Sullivan Health Care Center
28			Sunset Manor Nursing Home
29			Swansea Rehab & Health Care
30			Timbercreek Rehab & Health Cent

tions (parties) as defined in the instructions.

URSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
	City	Name	City	Type of Business
	Sullivan			
e Center	McLeansboro			
	Mt. Vernon			
nter	Newman			
nter	Nokomis			
	North Aurora			
re Center	Princeton			
	Mattoon			
	Piper City			
e Center	Morrison			
Center	Polo			
Center	Prairie City			
	Brighton			
	Rochelle			
nter	Rochelle			
enter	Rock Falls			
	Rock Falls			
Center	Roseville			
nter	Rosiclare			
	Kewanee			
enter	Sandwich			
	Sandwich			
	Harrisburg			
Center	Shelbyville			
Center	South Elgin			
	Watseka			
	Sullivan			
	Canton			
	Swansea			
er	Pekin			

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Facility Name & ID Number Rosiclare Rehab & Hlth C Ctr

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizat

	1 OWNERS		2 RELATED NU
	Name	**Ownership %**	**Name**
1			Toulon Health Care Center
2			Tuscola Health Care Center
3			Twin Lakes Rehab & Health Care (
4			Vandalia Rehab & Health Care Ce
5			Watseka Health Care Center
6			Westside Rehab & Care Center
7			Whispering Oaks
8			White Oak Rehab & Health Care C
9			Willow Rose Rehab & Health Care
10			Sheldon Health Care Center
11			Tuscola Health Care Center
12			Effingham Health Care Center
13			Collinsville Health Care Center
14			Ozark Rehab & Health Care Cente
15			South Shore Health Care, LLC
16			Cedargate Skilled Nursing Facility
17			Tarkio Rehab & Health Care Cent
18			Shangri-la Rehab & Living Center
19			Prairie Rose Care Center
20			Illini Heritage Rehab & Health Cer
21			Courtyard Estates of Kewanee
22			Courtyard Estates of Bradford
23			Courtyard Estates of Galva
24			Courtyard Estates of Walcott
25			Courtyard Village of Kewanee
26			Lakewood Village
27			Courtyard Estates of Monmouth
28			Riverview Estates
29			Simple Blessings
30			Courtyard Estates of Bushnell

tions (parties) as defined in the instructions.

JRSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
	City	Name	City	Type of Business
	Toulon			
	Tuscola			
Center	Paris			
nter	Vandalia			
	Watseka			
	West Frankfort			
	Rosiclare			
Center	Mt. Vernon			
Center	Jerseyville			
	Sheldon			
	Tuscola			
	Effingham			
	Collinsville			
r	Osage Beach, MO			
	Gary, IN			
	Poplar Bluff, MO			
er	Tarkio, MO			
	Blue Springs, MO			
	Pana			
nter	Champaign			
	Kewanee			
	Bradford			
	Galva			
	Walcott			
	Kewanee			
	Charleston			
	Monmouth			
	Havana			
	Casey			
	Bushnell			

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Facility Name & ID Number Rosiclare Rehab & Hlth C Ctr

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizat

	1 OWNERS		2 RELATED NU
	Name	**Ownership %**	**Name**
1			Courtyard Estates of Canton
2			Legacy Estates of Monmouth
3			Courtyard Estates of Sullivan
4			Courtyard Estates of Peoria
5			Cornerstone Health and Rehabilita
6			
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0047548 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

tions (parties) as defined in the instructions.

JRSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
	City	Name	City	Type of Business
	Canton			
	Monmouth			
	Sullivan			
	Peoria			
tion	Peoria			

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VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of I

NOTE: ALL owners (even those with less than 5% ownership) and their re must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest
1				
2				
3				
4	N/A			
5				
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* If the owner(s) of this facility or any other related parties listed above have receive of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE A

** This must include all forms of compensation paid by related entities and all FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FO ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RES

Board of Directors.
elatives who receive any type of compensation from this home

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
						2
						3
						4
						5
						6
						7
						8
						9
						10
						11
						12
			TOTAL	$		13

ed compensation from other nursing homes, attach a schedule detailing the name(s)
AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS

ocated to Schedule V of this report (i.e., management fees).
RMS OF COMPENSATION RECEIVED FROM THIS HOME,
ULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Rosiclare Rehab & Hlth C Ctr #

VIII. ALLOCATION OF INDIRECT COSTS

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	Su All
1	1	Dietary	Resident Days	1,560,986	
2	2	Food	Resident Days	1,560,986	
3	3	Housekeeping	Resident Days	1,560,986	
4	4	Laundry	Resident Days	1,560,986	
5	5	Utilities	Resident Days	1,560,986	
6	6	Maintenance	Resident Days	1,560,986	
7	7	Mgmt. Allocation of Benefits	Resident Days	1,560,986	
8	10	Nursing and Medical Records	Resident Days	1,560,986	
9	10A	Therapy	Resident Days	1,560,986	
10	15	Mgmt. Allocation of Benefits	Resident Days	1,560,986	
11	17	Administrative	Resident Days	1,560,986	
12	19	Professional Services	Resident Days	1,560,986	
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,560,986	
14	21	Clerical and General Office	Resident Days	1,560,986	
15	23	Inservice Training & Education	Resident Days	1,560,986	
16	24	Travel and Seminar	Resident Days	1,560,986	
17	25	Other Admin. Staff Transport.	Resident Days	1,560,986	
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,560,986	
19	27	Mgmt. Allocation of Benefits	Resident Days	1,560,986	
20	30	Depreciation	Resident Days	1,560,986	
21	32	Interest	Resident Days	1,560,986	
22	33	Real Estate Taxes	Resident Days	1,560,986	
23	34	Rent-Facility and Grounds	Resident Days	1,560,986	
24	35	Rent-Equipment & Vehicles	Resident Days	1,560,986	
25	TOTALS				

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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

5 Number of ıbunits Being ocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6
75	$ 307,592	$ 295,212	16,683	$ 3,287
75	6,577	0	16,683	70
75	3,057	0	16,683	33
75	0	0	16,683	0
75	23,338	0	16,683	249
75	150,672	97,358	16,683	1,610
75	17,394	0	16,683	186
75	1,082	0	16,683	12
75	0	0	16,683	0
75	0	0	16,683	0
75	4,578,456	4,578,456	16,683	76,864
75	648,504	0	16,683	6,931
75	41,231	0	16,683	441
75	3,812,055	3,383,297	16,683	40,741
75	6,148	0	16,683	66
75	313	0	16,683	3
75	284,745	0	16,683	3,043
75	54,993	0	16,683	588
75	352,851	0	16,683	3,771
75	252,711	0	16,683	2,701
75	420,365	0	16,683	4,493
75	24,742	0	16,683	264
75	0	0	16,683	0
75	45,546	0	16,683	487
	$ 11,032,372	$ 8,354,323		$ 145,840

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Facility Name & ID Number Rosiclare Rehab & Hlth C Ctr #

VIII. ALLOCATION OF INDIRECT COSTS

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	Su All
1	1	Dietary	Resident Days	408,598	
2	2	Food	Resident Days	408,598	
3	3	Housekeeping	Resident Days	408,598	
4	4	Laundry	Resident Days	408,598	
5	5	Utilities	Resident Days	408,598	
6	6	Maintenance	Resident Days	408,598	
7	7	Mgmt. Allocation of Benefits	Resident Days	408,598	
8	10	Nursing and Medical Records	Resident Days	408,598	
9	12	Social Services	Resident Days	408,598	
10	17	Administrative	Resident Days	408,598	
11	19	Professional Services	Resident Days	408,598	
12	20	Dues, Fees, Subs & Promotions	Resident Days	408,598	
13	21	Clerical and General Office	Resident Days	408,598	
14	22	Employee Benefits & Payroll	Resident Days	408,598	
15	23	Inservice Training & Education	Resident Days	408,598	
16	24	Travel and Seminar	Resident Days	408,598	
17	25	Other Admin. Staff Transport.	Resident Days	408,598	
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	408,598	
19	27	Mgmt. Allocation of Benefits	Resident Days	408,598	
20	30	Depreciation	Resident Days	408,598	
21	32	Interest	Resident Days	408,598	
22	33	Real Estate Taxes	Resident Days	408,598	
23	34	Rent-Facility and Grounds	Resident Days	408,598	
24	35	Rent-Equipment & Vehicles	Resident Days	408,598	
25	TOTALS				

0047548 Report Period Beginning: 1/1/2013 Ending: 2/31/2013

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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

5 Number of ıbunits Being ocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6
21	$	$	16,683	$
21			16,683	
21			16,683	
21			16,683	
21			16,683	
21			16,683	
21			16,683	
21			16,683	
21			16,683	
21			16,683	
21	1,966,927		16,683	80,309
21	16,972		16,683	693
21	76,520		16,683	3,124
21	(465)		16,683	(19)
21			16,683	
21			16,683	
21			16,683	
21			16,683	
21			16,683	
21	4,500		16,683	184
21	710,525		16,683	29,011
21			16,683	
21			16,683	
21			16,683	
	$ 2,774,979	$		$ 113,302

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Facility Name & ID Number Rosiclare Rehab & Hlth C Ctr #

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required
	A. Directly Facility Related				
	Long-Term				
1	Bank of America		X	Mortgage	Varies
2					
3					
4					
5					
	Working Capital				
6					
7					
8					
9	TOTAL Facility Related				
	B. Non-Facility Related*				
10					
11					
12					
13					
14	TOTAL Non-Facility Related				
15	TOTALS (line 9+line14)				

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sc

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

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

necessary.)

5	6		7	8	9	10	
Date of Note	Amount of Note			Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	Original		Balance				
1/19/07	$	3,500,000	$ 2,613,898	12/31/13	Varies	$ 94,281	1
							2
							3
							4
							5
							6
							7
							8
	$	3,500,000	$ 2,613,898			$ 94,281	9
							10
			Interest Income Offset			(11,323)	11
			Home Office Allocation-PHC			4,493	12
			Home Office Allocation-PHO			29,011	13
	$		$			$ 22,181	14
	$	3,500,000	$ 2,613,898			$ 116,462	15

:h. V. $ _____ Line # _____

equently, page 4, col. 7.

in column 2.

Facility Name & ID Number Rosiclare Rehab & Hlth C Ctr

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report. **Important, please see the next works statement and bill must accompany t**

2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment c

3. Under or (over) accrual (line 2 minus line 1).

4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the li

5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other ge
(Describe appeal cost below. Attach copies of invoices to support the cost and a c

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.
TOTAL REFUND $ _____ **For** _____ **Tax Year.** **(Attach a copy of the**

7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2008	**5,162**	**8**
	2009	**5,281**	**9**
	2010	**5,412**	**10**
	2011	**5,392**	**11**
	2012	**5,488**	**12**

Accrual based on prior year tax bill.

NOTES:

1. **Please indicate a negative number by use of brackets( ). Dec taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you mu application for real estate tax exemption unless the building** **This denial must be no more than four years old at**

sheet, "RE_Tax". The real estate tax the cost report.		$ 5,556	1
overs more than one year, detail below.)	2012	$ 5,488	2
		$ (68)	3
nes below.)		$ 5,652	4
eneral operating costs on Schedule V, sections A, B or C. copy of the appeal filed with the county.)		$	5
Home Office Allocation real estate tax appeal board's decision.)		264 $	6
		$ 5,848	7

		FOR BHF USE ONLY		
	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

duct any overaccrual of

ust attach a denial of an
is rented from a for-profit entity.
t the time the cost report is filed.

2012 LONG TERM CARE REAL ESTATE TA

FACILITY NAME Rosiclare Rehab & Hlth C Ctr

FACILITY IDPH LICENSE NUMBER 0047548

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

TELEPHONE (309) 691-8113 FAX #: (309) 691

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

Enter the tax index number and real estate tax assessed for 2012 on the lines provi
cost that applies to the operation of the nursing home in Column D. Real estate ta
home property which is vacant, rented to other organizations, or used for purposes
entered in Column D. Do not include cost for any period other than calendar year

	(A) Tax Index Number	(B) Property Description	
1.	06-82-001-02-000	Long-Term Care Facility	$
2.			$
3.			$
4.			$
5.			$
6.			$
7.			$
8.			$
9.			$
10.			$
		TOTALS	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant prop
used for nursing home services? _____ YES _____ NO

If YES, attach an explanation and a schedule which shows the calculation of the c
(Generally the real estate tax cost must be allocated to the nursing home based upc

C. **Tax Bills**

Attach a copy of the original 2012 tax bills which were listed in Section A to this s
tax bill which is normally paid during 2013.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is
documentation . Facilities located in Cook County are required to provide
installment tax bill.

X STATEMENT

COUNTY Hardin

-8622

ded below. Enter only the portion of the
x applicable to any portion of the nursing
; other than long term care must not be
2012.

(C) Total Tax	(D) Tax Applicable to Nursing Home
5,488.04	$ 5,488.04
	$
	$
	$
	$
	$
	$
	$
	$
5,488.04	$ 5,488.04

erty, or property which is not directly

ost allocated to the nursing home.
on sq. ft. of space used.)

statement. Be sure to use the 2012

not considered acceptable tax bill
copies of their original **second**

Facility Name & ID Number Rosiclare Rehab & Hlth C Ctr

X. BUILDING AND GENERAL INFORMATION:

A. **Square Feet:** 12,600 **B. General Construction Type:** Exterior

C. **Does the Operating Entity?** [X] **(a) Own the Facility** [ ] **(b) Rent from a**

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedul

D. **Does the Operating Entity?** [X] **(a) Own the Equipment** [ ] **(b) Rent equipr**

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Sched

E. **List all other business entities owned by this operating entity or related to the operating entity that a (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, ind List entity name, type of business, square footage, and number of beds/units available (where applic**

N/A

F. **Does this cost report reflect any organization or pre-operating costs which are being amortized? If so, please complete the following:**

1. Total Amount Incurred:

3. Current Period Amortization:

Nature of Costs:

(Attach a complete schedule detailing the total amount o

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet
1	Facility	304,920
2		
3	TOTALS	304,920

Masonry Frame Metal Number of Stories 1

ı Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

e XI or Schedule XII-A. See instructions.)

nent from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.

lule XI-C or Schedule XII-B. See instructions.)

ıre located on or adjacent to this nursing home's grounds
ependent living facilities, CNA training facilities, etc.)
able).

☐ YES ☒ NO

2. Number of Years Over Which it is Being Amortized:

4. Dates Incurred:

f organization and pre-operating costs.)

	3 Year Acquired	4 Cost	
	2005	$ 74,250	1
			2
		$ 74,250	3

Facility Name & ID Number Rosiclare Rehab & Hlth C Ctr

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.)

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	
4	62		2005	1975	$
5					
6					
7					
8					
	Improvement Type**				
9	Original Land Improvements			2005	
10	Sidewalks			2006	
11	Sidewalks			2007	
12	Parking Lot Resurfacing			2008	
13	Heat Pump-5-Ton			2008	
14	Sprinkler System Repair			2008	
15	Sprinkler System Repair			2008	
16	Dry Pendant Installation (23)			2008	
17	Sprinkler System Repair			2009	
18	Nurse Call System			2010	
19	Sewer Repair			2013	
20	Nurse Call System			2013	
21					
22					
23					
24					
25					
26					
27					
28					
29					
30	Land Improvements Booked				
31	Building Booked				
32	Building Improvement Booked				
33					
34	2013-Home Office Allocation-Building Improvements				
35	2013-Home Office Allocation-Land Improvements				
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.

STATE OF ILLINOIS

0047548 Report Period Beginning: 1/1/2013 Ending:

Round all numbers to nearest dollar.

4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	Ac De
1,347,250	$		$ 53,890	$ 53,890	$
15,000		15	1,000	1,000	
1,600		15	107	107	
2,400		15	160	160	
15,063		39	386	386	
4,940		5	988	988	
16,695		39	428	428	
14,500		39	372	372	
2,812		20	140	140	
16,205		7	2,316	2,316	
7,905		10	790	790	
3,090		7	221	221	
5,585		7	399	399	
	1,653			(1,653)	
	53,927			(53,927)	
	4,841			(4,841)	
7,844			188	188	
732			47	47	

See Page 12A, Line 70 for total

9 ccumulated epreciation	
404,175	4
	5
	6
	7
	8
8,500	9
802	10
1,040	11
2,123	12
5,434	13
2,354	14
2,046	15
770	16
10,422	17
2,765	18
221	19
399	20
	21
	22
	23
	24
	25
	26
	27
	28
	29
	30
	31
	32
	33
	34
	35
	36

Facility Name & ID Number Rosiclare Rehab & Hlth C Ctr

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.)

	1 Improvement Type**	3 Year Constructed	
37			$
38			
39			
40			
41			
42			
43			
44			
45			
46			
47			
48			
49			
50			
51			
52			
53			
54			
55			
56			
57			
58			
59			
60			
61			
62			
63			
64			
65			
66			
67			
68			
69			
70	TOTAL (lines 4 thru 69)		$

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

STATE OF ILLINOIS

0047548 Report Period Beginning: 1/1/2013 Ending:

) Round all numbers to nearest dollar.

4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	Ac De
	$		$	$	$
1,461,621	$ 60,421		$ 61,432	$ 1,011	$

9 ccumulated epreciation	
	37
	38
	39
	40
	41
	42
	43
	44
	45
	46
	47
	48
	49
	50
	51
	52
	53
	54
	55
	56
	57
	58
	59
	60
	61
	62
	63
	64
	65
	66
	67
	68
	69
441,051	70

Facility Name & ID Number Rosiclare Rehab & Hlth C Ctr # 0047548

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	
71	Purchased in Prior Years	$ 13,792	$
72	Current Year Purchases	6,821	
73	Fully Depreciated Assets	260,260	
74	Home Office Allocation		
75	TOTALS	$ 280,873	$

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost
76				$
77				
78				
79				
80	TOTALS			$

E. Summary of Care-Related Assets

		Re
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) +
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B th
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B th
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B th
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B th

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		$	$	$
87	N/A			
88				
89				
90				
91	TOTALS	$	$	$

Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
1,302	$ 1,380	$ 78	5-10 yrs.	$ 7,508	71
350	341	(9)	10 yrs.	341	72
				260,260	73
	2,650	2,650			74
1,652	$ 4,371	$ 2,719		$ 268,109	75

Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
$	$	$		$	76
					77
					78
					79
$	$	$		$	80

1 eference	2 Amount		
(Pages 12B thru 12I, if applicable)	$ 1,816,744	81	
ru 12I, if applicable)	$ 62,073	82	
ru 12I, if applicable)	$ 65,803	83	**
ru 12I, if applicable)	$ 3,730	84	
ru 12I, if applicable)	$ 709,160	85	

G. Construction-in-Progress

		Description	Cost	
86	92		$	92
87	93	N/A		93
88	94			94
89	95		$	95
90				
91				

* 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.

STA

Facility Name & ID Number Rosiclare Rehab & Hlth C Ctr #

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, c
   If NO, see instructions. ☐

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

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? ☐
16. Rental Amount for movable equipment: $ 38,893 Description: See A

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	
17	Facility	Ford E250 Van	$ 828.41	$
18				
19				
20				
21	TOTAL		$ 828.41	$

column 4?
YES ☐ NO

5 Total Years of Lease	6 Total Years Renewal Option*	
		3
		4
		5
		6
		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	$

YES ☒ NO
Attached Schedule 14A
(Attach a schedule detailing the breakdown of movable equipment)

4 Rental Expense for this Period	
9,664	17
	18
	19
	20
9,664	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.

Rosiclare Rehab & Hlth C Ctr
0047548
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	$	31,618
Dishwasher		653
Laundry Equipment		-
Copier		6,135
Home Office Allocation		487
		38,893

Facility Name & ID Number Rosiclare Rehab & Hlth C Ctr

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

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a sch

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

[ ] YES
[X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PO
IN-HOUSE PROG
IN OTHER FACII
COMMUNITY CC
HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS

			1	2	
			Facility		
			Drop-outs	Completed	
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)	$		

(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.

tructions.)

edule listing the facility name, address and cost per CNA trained in that facility.)

RTION:		3. CLINICAL PORTION:	
RAM	☐	IN-HOUSE PROGRAM	☐
LITY	☐	IN OTHER FACILITY	☐
OLLEGE	☐	HOURS PER CNA	____
	____		

(d)

3	4
Contract	Total
	$
	$

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	

(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.

Facility Name & ID Number Rosiclare Rehab & Hlth C Ctr

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

		1	2	
	Service	Schedule V Line & Column Reference	Staff Units of Service	
1	Licensed Occupational Therapist	10A(3)	hrs	$
2	Licensed Speech and Language Development Therapist	10A(3)	hrs	
3	Licensed Recreational Therapist		hrs	
4	Licensed Physical Therapist	10A(3), 10A(2)	hrs	
5	Physician Care		visits	
6	Dental Care		visits	
7	Work Related Program		hrs	
8	Habilitation		hrs	
9	Pharmacy	39(2)	# of prescrpts	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs	
11	Academic Education		hrs	
12	Other (specify):			
13	Other (specify):			
14	TOTAL			$

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitio Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with tl on this schedule.

STATE OF ILLINOIS
0047548 Report Period Beginning: 1/1/2013 Ending:

3	4	5	6	7	
Cost	Outside Practitioner (other than consultant)		Supplies (Actual or)	Total Units	To
	Units	Cost	Allocated)	(Column 2 + 4)	(Col.
	6,225	$ 93,376	$	6,225	$
	5,079	76,181		5,079	
	8,712	130,676	82	8,712	
			83,097		
	20,016	$ 300,233	$ 83,179	20,016	$

ners. Consultant fees should be detailed on
he above activities should not be listed

8	
tal Cost . 3 + 5 + 6)	
93,376	1
76,181	2
	3
130,758	4
	5
	6
	7
	8
83,097	9
	10
	11
	12
	13
383,412	14

Facility Name & ID Number **Rosiclare Rehab & Hlth C Ctr** **STATE #**

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of**

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 5,548,713	$ 5,548,713	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 67,941)	349,200	349,200	3
4	Supply Inventory (priced at)	8,794	8,794	4
5	Short-Term Investments			5
6	Prepaid Insurance	21,905	21,905	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Security Deposit/PPD Lease	5,419	5,419	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,934,031	$ 5,934,031	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	108,313	74,250	13
14	Buildings, at Historical Cost	1,347,250	1,355,094	14
15	Leasehold Improvements, at Historical Cost	71,732	106,527	15
16	Equipment, at Historical Cost	280,873	280,873	16
17	Accumulated Depreciation (book methods)	(750,287)	(709,160)	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	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,057,881	$ 1,107,584	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,991,912	$ 7,041,615	25

***(See in**

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 613,447	$ 613,447	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	19,357	19,357	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,037	4,037	31
32	Accrued Real Estate Taxes(Sch.IX-B)	5,652	5,652	32
33	Accrued Interest Payable	7,132	7,132	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	37,242	37,242	36
37	Accrued Management Fees	230,050	230,050	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 916,917	$ 916,917	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,613,898	2,613,898	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Intercompany Loans	1,448,043	1,448,043	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 4,061,941	$ 4,061,941	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,978,858	$ 4,978,858	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,013,054	$ 2,062,757	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,991,912	$ 7,041,615	48

ıstructions.)

Facility Name & ID Number Rosiclare Rehab & Hlth C Ctr #

XVI. STATEMENT OF CHANGES IN EQUITY

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

1 Total		
2,155,159	1	
	2	
1	3	
	4	
	5	
2,155,160	6	
(142,106)	7	
	8	
	9	
	10	
	11	
	12	
)	13	
	14	
	15	
	16	
(142,106)	17	
	18	
	19	
	20	
	21	
	22	
	23	
2,013,054	24	*

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

STATE OF ILLINOI

Facility Name & ID Number Rosiclare Rehab & Hlth C Ctr # 0047548

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this sched
classifications of revenue and expense must be provided on this form, even if financial statem
Note: This schedule should show gross revenue and expenses. Do not net revenue

		1		
	I. Revenue	**Amount**		
	A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	$ 2,259,953	1	31
2	Discounts and Allowances for all Levels	(304,388)	2	32
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,955,565	3	33
	B. Ancillary Revenue			
4	Day Care		4	34
5	Other Care for Outpatients		5	
6	Therapy	435,801	6	35
7	Oxygen	418	7	36
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 436,219	8	
	C. Other Operating Revenue			37
9	Payments for Education		9	38
10	Other Government Grants		10	39
11	CNA Training Reimbursements		11	
12	Gift and Coffee Shop		12	40
13	Barber and Beauty Care		13	
14	Non-Patient Meals	2,778	14	41
15	Telephone, Television and Radio		15	
16	Rental of Facility Space		16	42
17	Sale of Drugs	141,852	17	
18	Sale of Supplies to Non-Patients		18	43
19	Laboratory		19	
20	Radiology and X-Ray	16,717	20	
21	Other Medical Services	8,498	21	44
22	Laundry		22	45
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 169,845	23	46
	D. Non-Operating Revenue			47
24	Contributions		24	48
25	Interest and Other Investment Income***	11,323	25	49
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 11,323	26	
	E. Other Revenue (specify):**			*
27	**Settlement Income (Insurance, Legal, Etc.)**		27	**
28	**Miscellaneous Revenue**	138	28	
28a	**Transportation Revenue**	16,839	28a	***
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 16,977	29	
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,589,929	30	****]

Report Period Beginning: 1/1/2013 **Ending:** 12/31/2013

ule to Schedules V and VI.) All required
ents are attached.
e against expense.

	2	
II. Expenses	**Amount**	
A. Operating Expenses		
General Services	**429,725**	**31**
Health Care	**1,138,020**	**32**
General Administration	**655,102**	**33**
B. Capital Expense		
Ownership	**210,008**	**34**
C. Ancillary Expense		
Special Cost Centers	**175,666**	**35**
Provider Participation Fee	**123,514**	**36**
D. Other Expenses (specify):		
		37
		38
		39
TOTAL EXPENSES (sum of lines 31 thru 39)*	**$ 2,732,035**	**40**
Income before Income Taxes (line 30 minus line 40)**	**(142,106)**	**41**
Income Taxes		**42**
NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	**$ (142,106)**	**43**

III. Net Inpatient Revenue detailed by Payer Source		
Medicaid - Net Inpatient Revenue	**$ 1,356,239**	**44**
Private Pay - Net Inpatient Revenue	**231,214**	**45**
Medicare - Net Inpatient Revenue	**373,541**	**46**
Other-(specify) **Veterans -Net Patient Revenue**	**570**	**47**
Other-(specify) **Charity Contractual Allowance**	**(5,999)**	**48**
TOTAL Inpatient Care Revenue (This total must agree to Line 3)	**$ 1,955,565**	**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 Rosiclare Rehab & Hlth C Ctr #

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	1,993	1,993	$ 56,496	$ 28.35
2	Assistant Director of Nursing	1,865	1,999	53,888	26.96
3	Registered Nurses	7,175	7,616	162,767	21.37
4	Licensed Practical Nurses	7,174	7,634	114,490	15.00
5	CNAs & Orderlies	27,893	28,705	282,594	9.84
6	CNA Trainees				
7	Licensed Therapist				
8	Rehab/Therapy Aides				
9	Activity Director	1,817	1,956	23,886	12.21
10	Activity Assistants				
11	Social Service Workers				
12	Dietician				
13	Food Service Supervisor	1,993	1,993	30,456	15.28
14	Head Cook				
15	Cook Helpers/Assistants	7,341	7,891	71,350	9.04
16	Dishwashers				
17	Maintenance Workers	1,636	1,944	25,104	12.91
18	Housekeepers	6,908	7,204	74,719	10.37
19	Laundry	1,954	2,123	18,914	8.91
20	Administrator	2,080	2,080	76,864	36.95
21	Assistant Administrator				
22	Other Administrative				
23	Office Manager	1,317	1,938	31,598	16.30
24	Clerical				
25	Vocational Instruction				
26	Academic Instruction				
27	Medical Director				
28	Qualified MR Prof. (QMRP)				
29	Resident Services Coordinator				
30	Habilitation Aides (DD Homes)				
31	Medical Records				
32	Other Health Ca CPC	1,993	1,993	40,628	20.39
33	Other(specify) Transportation	1,537	1,566	13,664	8.73
34	TOTAL (lines 1 - 33)	74,676	78,635	$ 1,077,418 *	$ 13.70

* 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
1					
2	35	Dietary Consultant	69	$ 3,472	L1, C3
3	36	Medical Director	Monthly	4,800	L9, C3
4	37	Medical Records Consultant			
5	38	Nurse Consultant			
6	39	Pharmacist Consultant	Monthly	3,288	L10, C3
7	40	Physical Therapy Consultant			
8	41	Occupational Therapy Consultant			
9	42	Respiratory Therapy Consultant	4	220	L10, C3
10	43	Speech Therapy Consultant			
11	44	Activity Consultant			
12	45	Social Service Consultant			
13	46	Other(specify)			
14	47				
15	48				
16					
17	49	TOTAL (lines 35 - 48)	73	$ 11,780	
18					
19					
20					
21					

C. CONTRACT NURSES

			1	2	3
			Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference
22					
23					
24					
25					
26					
27	50	Registered Nurses		$	
28	51	Licensed Practical Nurses	N/A		
29	52	Certified Nurse Assistants/Aides			
30					
31	53	TOTAL (lines 50 - 52)		$	
32					
33					
34					


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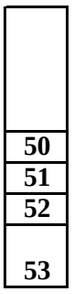
50
51
52
53

Facility Name & ID Number Rosiclare Rehab & Hlth C Ctr

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Lucinda Spivey	Administrator	0	$ 56,447
Sarah Little	Administrator	0	20,417
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 76,864

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 250,600
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 250,600

C. Professional Services

Vendor/Payee	Type	Amount
E-Health Data Solutions	Computer Services	$ 6,763
Shawnee Communications	Computer Services	329
Honkamp Krueger & Co.	Accounting Fees	703
Comcast	Computer Services	80
Gail and Rice	Accounting Fees	614
Consolidated Land Surveying	Surveying Fees	1,400
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 9,889

STATE OF ILLINOIS
0047548 Report Period Beginning: 1/1/2013

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 31,611
Unemployment Compensation Insurance	32,908
FICA Taxes	75,295
Employee Health Insurance	17,602
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	3,578
Employee Retirement	247
Home Office Allocation	(19)
TOTAL (agree to Schedule V, line 22, col.8)	$ 161,222

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and P

Description
IDPH License Fee
Advertising: Employee Recruitme
Health Care Worker Background
(Indicate # of checks performed
Patient Background Checks
Miscellaneous Licenses & Permits
Miscellaneous Dues & Subscriptio
Home Office Allocation
Less: Public Relations Expense
Non-allowable advertising
Yellow page advertising
TOTAL (agree to Sch. line 20, col. 8)

G. Schedule of Travel and Semina

Description
Out-of-State Travel
In-State Travel
Seminar Expense
Home Office Allocation
Entertainment Expense
TOTAL (agree to Sch. V, line 24, col. 8)

* Attach copy of IMRF notifications

**See instructions.

romotions

		Amount
	$	3,980
nt		75
Check		
)		
96		963
		108
ns		106
		1,134
	(	)
	(	)
	(	)
V,	$	6,366

r**

		Amount
	$	
		3
	(	)
	$	3

Rosiclare Rehab & Hlth C Ctr
0047548
Period Beginning **1/1/2013**
Period End **12/31/2013**

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	**Type**	**Amount**
Total (agree to Schedule V, line 19, column 3)		9,889
Home Office Allocation		
SmithAmundsen	Legal	412
Cole, Schotz, Meisel	Legal	227
Black, Hedin, Ballard	Legal	21
Elias, Meginnes, Riffle & Seghetti	Legal	41
Miller, Hall, and Triggs	Legal	867
Evapar	Legal	167
Ginoli & Company	Accountants	2385
E-Health Data Solutions	Computer Services	2967
Miscellaneous	Computer Services	62
Odessian LLC	Computer Services	32
CCH	Computer Services	10
Lexis-Nexis	Computer Services	4
Ipanema Solutions	Computer Services	9
Macquarie Technology Services	Computer Services	59
Advanced Answers on Demand	Computer Services	3051
TeamViewer	Computer Services	10
Stratus Networks	Computer Services	246
Kemper Technology	Computer Services	190
AT&T	Computer Services	3
Medifax	Computer Services	28
Vision Share/Ability Network	Computer Services	418
Barracuda	Computer Services	75
CIAN	Computer Services	100
Comcast	Computer Services	22
Emdeon	Computer Services	34
Marotta Gund Budd & Dzera	Other Prof Fees	74469
David Budde	Other Prof Fees	19
Pharmacy Price Mangement	Other Prof Fees	384
All Scripts	Other Prof Fees	684
Registered Agent Solutions	Other Prof Fees	32
Healthink	Other Prof Fees	212
Total (agree to Schedule V, line 19, column 8)		97,129

STATE OF IL

Facility Name & ID Number Rosiclare Rehab & Hlth C Ctr #

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in S

(See instructions.)

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

ch. V, line 6, col. 3).

7	8	9	10	11	12	13
	Amount of Expense Amortized Per Year					
FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
	$	$	$	$	$	$
	$	$	$	$	$	$

Facility Name & ID Number **Rosiclare Rehab & Hlth C Ctr**

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. $ **14,746** 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. $ **123,514**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **2,778**

(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. $ **16,839**

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 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.