

Facility Name & ID Number Watseka Rehab & HCC

0046847 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	<u>123</u>	Skilled (SNF)	<u>123</u>	<u>44,895</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>123</u>	TOTALS	<u>123</u>	<u>44,895</u>	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	<u>25,774</u>	<u>6,748</u>	<u>2,701</u>	<u>35,223</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>25,774</u>	<u>6,748</u>	<u>2,701</u>	<u>35,223</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.46%

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 NO

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

YES NO

I. On what date did you start providing long term care at this location?

Date started 1/1/2005

J. Was the facility purchased or leased after January 1, 1978?

YES Date 1/1/2005 NO

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

YES NO If YES, enter number of beds certified 123 and days of care provided 2,050

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 & ID Number

Watseka Rehab & HCC

0046847

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
	A. General Services										
1	Dietary	166,390	12,043		178,433		178,433	6,941	185,374		1
2	Food Purchase		200,699		200,699		200,699	(8,293)	192,406		2
3	Housekeeping	164,291	27,797		192,088		192,088	69	192,157		3
4	Laundry	10,389	17,368		27,757		27,757		27,757		4
5	Heat and Other Utilities			108,929	108,929		108,929	527	109,456		5
6	Maintenance	34,554	14,312	24,464	73,330		73,330	3,417	76,747		6
7	Other (specify):* Home Off. Ben. All.							393	393		7
8	TOTAL General Services	375,624	272,219	133,393	781,236		781,236	3,054	784,290		8
	B. Health Care and Programs										
9	Medical Director			6,600	6,600		6,600		6,600		9
10	Nursing and Medical Records	1,538,310	179,959	10,277	1,728,546		1,728,546	(5,609)	1,722,937		10
10a	Therapy			320,235	320,235		320,235		320,235		10a
11	Activities	141,386	877		142,263		142,263	(29,648)	112,615		11
12	Social Services	26,993			26,993		26,993		26,993		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.										15
16	TOTAL Health Care and Programs	1,706,689	180,836	337,112	2,224,637		2,224,637	(35,257)	2,189,380		16
	C. General Administration										
17	Administrative			317,000	317,000		317,000	(244,000)	73,000		17
18	Directors Fees										18
19	Professional Services			207,197	207,197		207,197	28,231	235,428		19
20	Dues, Fees, Subscriptions & Promotions			9,673	9,673		9,673	559	10,232		20
21	Clerical & General Office Expenses	31,292	7,557	15,643	54,492		54,492	105,567	160,059		21
22	Employee Benefits & Payroll Taxes			282,829	282,829		282,829	843	283,672		22
23	Inservice Training & Education			4,600	4,600		4,600	139	4,739		23
24	Travel and Seminar							7	7		24
25	Other Admin. Staff Transportation			11,508	11,508		11,508	6,425	17,933		25
26	Insurance-Prop.Liab.Malpractice			44,715	44,715		44,715	1,241	45,956		26
27	Other (specify):* Home Off. Ben. All.							7,962	7,962		27
28	TOTAL General Administration	31,292	7,557	893,165	932,014		932,014	(93,026)	838,988		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,113,605	460,612	1,363,670	3,937,887		3,937,887	(125,229)	3,812,658		29

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

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

Facility Name & ID Number

Watseka Rehab & HCC

#0046847

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	
	D. Ownership											
30	Depreciation			203,009	203,009		203,009	40,332	243,341			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			113,430	113,430		113,430	143,555	256,985			32
33	Real Estate Taxes			78,685	78,685		78,685	558	79,243			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			37,763	37,763		37,763	1,028	38,791			35
36	Other (specify):*											36
37	TOTAL Ownership			432,887	432,887		432,887	185,473	618,360			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		105,363		105,363		105,363		105,363			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			267,532	267,532		267,532		267,532			42
43	Other (specify):* Non-allowable Costs	9,954	1,165	67,255	78,374		78,374	(78,374)				43
44	TOTAL Special Cost Centers	9,954	106,528	334,787	451,269		451,269	(78,374)	372,895			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,123,559	567,140	2,131,344	4,822,043		4,822,043	(18,130)	4,803,913			45

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

Facility Name & ID Number Watsseka Rehab & HCC

0046847

Report Period Beginning: 1/1/2013

Ending: 12/31/2013

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	(8,441)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,516)	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	1,830	30		9
10	Interest and Other Investment Income	(21,788)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(498)	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	(34,270)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		1 43		24
25	Fund Raising, Advertising and Promotional	(11,790)	43		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(61,873)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (143,345)		\$	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
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	125,215	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 125,215		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (18,130)		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

Watseka Rehab & HCC

ID# 0046847

Report Period Beginning: 1/1/2013

Ending: 12/31/2013

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Labs-Part A	\$ (8,820)	43	1
2	X-Rays-Part A	(8,073)	43	2
3	Disallowed Special Events	(93)	43	3
4	Resident Flowers	(469)	43	4
5	Offset Miscellaneous Office Supplies Revenue	(920)	21	5
6	Pet Expense	(1,160)	43	6
7	Offset Transportation Revenue	(29,648)	11	7
8	Offset Miscellaneous Nursing Revenue	(5,633)	10	8
9	Offset Chamber of Commerce Dues	(371)	20	9
10	Offset Disallowed Air Travel	(6,686)	43	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		(61,873)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Watseka Rehab & HCC# 0046847

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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	6,941	0	0	0	0	0	0	0	0	0	6,941	1
2	Food Purchase	(8,441)	148	0	0	0	0	0	0	0	0	0	(8,293)	2
3	Housekeeping	0	69	0	0	0	0	0	0	0	0	0	69	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	527	0	0	0	0	0	0	0	0	0	527	5
6	Maintenance	0	3,400	0	17	0	0	0	0	0	0	0	3,417	6
7	Other (specify):*	0	393	0	0	0	0	0	0	0	0	0	393	7
8	TOTAL General Services	(8,441)	11,478	0	17	0	0	0	0	0	0	0	3,054	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(5,633)	24	0	0	0	0	0	0	0	0	0	(5,609)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(29,648)	0	0	0	0	0	0	0	0	0	0	(29,648)	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	TOTAL Health Care and Programs	(35,281)	24	0	0	0	0	0	0	0	0	0	(35,257)	16
	C. General Administration													
17	Administrative	0	(244,000)	0	0	0	0	0	0	0	0	0	(244,000)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	14,633	0	13,598	0	0	0	0	0	0	0	28,231	19
20	Fees, Subscriptions & Promotions	(371)	0	930	0	0	0	0	0	0	0	0	559	20
21	Clerical & General Office Expenses	(920)	0	86,017	20,470	0	0	0	0	0	0	0	105,567	21
22	Employee Benefits & Payroll Taxes	0	0	0	843	0	0	0	0	0	0	0	843	22
23	Inservice Training & Education	0	0	139	0	0	0	0	0	0	0	0	139	23
24	Travel and Seminar	0	0	7	0	0	0	0	0	0	0	0	7	24
25	Other Admin. Staff Transportation	0	0	6,425	0	0	0	0	0	0	0	0	6,425	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,241	0	0	0	0	0	0	0	0	1,241	26
27	Other (specify):*	0	0	7,962	0	0	0	0	0	0	0	0	7,962	27
28	TOTAL General Administration	(1,291)	(229,367)	102,721	34,911	0	0	0	0	0	0	0	(93,026)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(45,013)	(217,865)	102,721	34,928	0	0	0	0	0	0	0	(125,229)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Watseka Rehab & HCC# 0046847

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)	
	D. Ownership													
30	Depreciation	1,830	0	5,702	32,800	0	0	0	0	0	0	0	40,332	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(21,788)	0	9,485	155,858	0	0	0	0	0	0	0	143,555	32
33	Real Estate Taxes	0	0	558	0	0	0	0	0	0	0	0	558	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	1,028	0	0	0	0	0	0	0	0	1,028	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(19,958)	0	16,773	188,658	0	0	0	0	0	0	0	185,473	37
	Ancillary Expense													
	E. Special Cost Centers													
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):*	(78,374)	0	0	0	0	0	0	0	0	0	0	(78,374)	43
44	TOTAL Special Cost Centers	(78,374)	0	0	0	0	0	0	0	0	0	0	(78,374)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(143,345)	(217,865)	119,494	223,586	0	0	0	0	0	0	0	(18,130)	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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 6,941	\$ 6,941	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	148	148	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	69	69	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	527	527	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	3,400	3,400	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	393	393	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	24	24	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	317,000	Petersen Health Care, Inc.	100.00%	73,000	(244,000)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	14,633	14,633	12
13	V							13
14	Total		\$ 317,000			\$ 99,135	\$ * (217,865)	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%	\$ 930	\$	930	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	86,017		86,017	16
17	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	139		139	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	7		7	18
19	V	25 Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	6,425		6,425	19
20	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	1,241		1,241	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	7,962		7,962	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	5,702		5,702	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	9,485		9,485	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	558		558	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%	1,028		1,028	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		\$			\$ 119,494	\$ *	119,494	39

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

Facility Name & ID Number

Watseka Rehab & HCC

0046847

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

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 Care II, Inc.	100.00%	\$ 0	\$	15	
16	V	2 Food		Petersen Health Care II, Inc.	100.00%	0		16	
17	V	3 Housekeeping		Petersen Health Care II, Inc.	100.00%	0		17	
18	V	4 Laundry		Petersen Health Care II, Inc.	100.00%	0		18	
19	V	5 Utilities		Petersen Health Care II, Inc.	100.00%	0		19	
20	V	6 Maintenance		Petersen Health Care II, Inc.	100.00%	17	17	20	
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	100.00%	0		21	
22	V	10 Nursing and Medical Records		Petersen Health Care II, Inc.	100.00%	0		22	
23	V	12 Social Services		Petersen Health Care II, Inc.	100.00%	0		23	
24	V	17 Administrative		Petersen Health Care II, Inc.	100.00%	0		24	
25	V	19 Professional Services		Petersen Health Care II, Inc.	100.00%	13,598	13,598	25	
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Care II, Inc.	100.00%	0		26	
27	V	21 Clerical and General Office		Petersen Health Care II, Inc.	100.00%	20,470	20,470	27	
28	V	22 Employee Benefits & Payroll		Petersen Health Care II, Inc.	100.00%	843	843	28	
29	V	23 Inservice Training & Education		Petersen Health Care II, Inc.	100.00%	0		29	
30	V	24 Travel and Seminar		Petersen Health Care II, Inc.	100.00%	0		30	
31	V	25 Other Admin. Staff Transport.		Petersen Health Care II, Inc.	100.00%	0		31	
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care II, Inc.	100.00%	0		32	
33	V	27 Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	100.00%	0		33	
34	V	30 Depreciation		Petersen Health Care II, Inc.	100.00%	32,800	32,800	34	
35	V	32 Interest		Petersen Health Care II, Inc.	100.00%	155,858	155,858	35	
36	V	33 Real Estate Taxes		Petersen Health Care II, Inc.	100.00%	0		36	
37	V	34 Rent-Facility and Grounds		Petersen Health Care II, Inc.	100.00%	0		37	
38	V	35 Rent-Equipment & Vehicles		Petersen Health Care II, Inc.	100.00%	0		38	
39	Total		\$			\$ 223,586	\$ *	223,586	39

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

Facility Name & ID Number

Watseka Rehab & HCC

0046847

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 & ID Number

Watsoka Rehab & HCC

0046847

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	Watsoka				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 & ID Number

Watseka Rehab & HCC

0046847

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

Watseka Rehab & HCC

0046847

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

Watseka Rehab & HCC

#

0046847

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 Watseka Rehab & HCC

0046847

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	35,223	\$ 6,941	1
2	2	Food	Resident Days	1,560,986	75	6,577	0	35,223	148	2
3	3	Housekeeping	Resident Days	1,560,986	75	3,057	0	35,223	69	3
4	4	Laundry	Resident Days	1,560,986	75	0	0	35,223	0	4
5	5	Utilities	Resident Days	1,560,986	75	23,338	0	35,223	527	5
6	6	Maintenance	Resident Days	1,560,986	75	150,672	97,358	35,223	3,400	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,560,986	75	17,394	0	35,223	393	7
8	10	Nursing and Medical Records	Resident Days	1,560,986	75	1,082	0	35,223	24	8
9	10A	Therapy	Resident Days	1,560,986	75	0	0	35,223	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,560,986	75	0	0	35,223	0	10
11	17	Administrative	Resident Days	1,560,986	75	4,578,456	4,578,456	35,223	73,000	11
12	19	Professional Services	Resident Days	1,560,986	75	648,504	0	35,223	14,633	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,560,986	75	41,231	0	35,223	930	13
14	21	Clerical and General Office	Resident Days	1,560,986	75	3,812,055	3,383,297	35,223	86,017	14
15	23	Inservice Training & Education	Resident Days	1,560,986	75	6,148	0	35,223	139	15
16	24	Travel and Seminar	Resident Days	1,560,986	75	313	0	35,223	7	16
17	25	Other Admin. Staff Transport.	Resident Days	1,560,986	75	284,745	0	35,223	6,425	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,560,986	75	54,993	0	35,223	1,241	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,560,986	75	352,851	0	35,223	7,962	19
20	30	Depreciation	Resident Days	1,560,986	75	252,711	0	35,223	5,702	20
21	32	Interest	Resident Days	1,560,986	75	420,365	0	35,223	9,485	21
22	33	Real Estate Taxes	Resident Days	1,560,986	75	24,742	0	35,223	558	22
23	34	Rent-Facility and Grounds	Resident Days	1,560,986	75	0	0	35,223	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,560,986	75	45,546	0	35,223	1,028	24
25	TOTALS					\$ 11,032,372	\$ 8,354,323		\$ 218,629	25

Facility Name & ID Number Watseka Rehab & HCC

0046847

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	161,888	7	\$	\$	35,223	\$	1
2	2	Food	Resident Days	161,888	7			35,223		2
3	3	Housekeeping	Resident Days	161,888	7			35,223		3
4	4	Laundry	Resident Days	161,888	7			35,223		4
5	5	Utilities	Resident Days	161,888	7			35,223		5
6	6	Maintenance	Resident Days	161,888	7	80		35,223	17	6
7	7	Mgmt. Allocation of Benefits	Resident Days	161,888	7			35,223		7
8	10	Nursing and Medical Records	Resident Days	161,888	7			35,223		8
9	15	Mgmt. Allocation of Benefits	Resident Days	161,888	7			35,223		9
10	17	Administrative	Resident Days	161,888	7			35,223		10
11	19	Professional Services	Resident Days	161,888	7	62,499		35,223	13,598	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	161,888	7			35,223		12
13	21	Clerical and General Office	Resident Days	161,888	7	94,081		35,223	20,470	13
14	22	Employee Benefits & Payroll	Resident Days	161,888	7	3,874		35,223	843	14
15	23	Inservice Training & Education	Resident Days	161,888	7			35,223		15
16	24	Travel and Seminar	Resident Days	161,888	7			35,223		16
17	25	Other Admin. Staff Transport.	Resident Days	161,888	7			35,223		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	161,888	7			35,223		18
19	27	Mgmt. Allocation of Benefits	Resident Days	161,888	7			35,223		19
20	30	Depreciation	Resident Days	161,888	7	150,752		35,223	32,800	20
21	32	Interest	Resident Days	161,888	7	716,337		35,223	155,858	21
22	33	Real Estate Taxes	Resident Days	161,888	7			35,223		22
23	34	Rent-Facility and Grounds	Resident Days	161,888	7			35,223		23
24	35	Rent-Equipment & Vehicles	Resident Days	161,888	7			35,223		24
25	TOTALS					\$ 1,027,623	\$		\$ 223,586	25

Facility Name & ID Number

Watseka Rehab & HCC

0046847

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			
A. Directly Facility Related																	
Long-Term																	
1	1st Merit		X	Mortgage	Varies	02/01/12	2,774,700	\$ 2,633,411	01/31/17	Varies	\$ 113,430						
2																	
3																	
4																	
5																	
Working Capital																	
6																	
7																	
8																	
9	TOTAL Facility Related						\$ 2,774,700	\$ 2,633,411			\$ 113,430						
B. Non-Facility Related*																	
10																	
11											(21,788)						
12											9,485						
13											155,858						
14	TOTAL Non-Facility Related						\$	\$			\$ 143,555						
15	TOTALS (line 9+line14)						\$ 2,774,700	\$ 2,633,411			\$ 256,985						

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**

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1. Real Estate Tax accrual used on 2012 report.				\$	78,240	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		\$	77,305	2
3. Under or (over) accrual (line 2 minus line 1).				\$	(935)	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	79,620	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. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$		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.					558	
TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	79,243	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2008	76,843	8	FOR BHF USE ONLY		
	2009	75,521	9	13	FROM R. E. TAX STATEMENT FOR 2012 \$	13
	2010	75,949	10	14	PLUS APPEAL COST FROM LINE 5 \$	14
	2011	75,962	11	15	LESS REFUND FROM LINE 6 \$	15
	2012	77,305	12	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
Accrual based on prior year tax bill.						

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.

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: 28,000 B. General Construction Type: Exterior Brick & Block Frame Steel 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>28,000</u>	<u>2005</u>	<u>\$ 120,000</u>	1
2					2
3	TOTALS	28,000		\$ 120,000	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	123	2005	1976	\$ 2,511,949	\$	30	\$ 83,732	\$ 83,732	\$ 753,587	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Parking lots, sidewalks & landscaping	2005		534,029		15	35,602	35,602	320,417	9
10	Sidewalks	2006		6,600		15	440	440	3,300	10
11	Roof	2007		7,678		15	512	512	3,328	11
12	Roof Repair	2008		3,276		39	84	84	462	12
13	Water Heater	2009		3,577		5	716	716	3,222	13
14	Water Heater	2009		2,885		5	578	578	2,601	14
15	Sprinkler Head Replacements	2010		22,838		15	1,522	1,522	5,327	15
16	Water Heater	2010		3,190		10	320	320	1,120	16
17	Roof Repair	2010		2,670		7	382	382	1,337	17
18	A/C Repair	2011		2,723		7	390	390	975	18
19	Wall and Roof Repair	2011		7,139		7	1,020	1,020	2,550	19
20	Lunchroom and Kitchen Roof Repairs	2013		4,450		7	318	318	318	20
21	Roof Repairs	2013		2,850		7	204	204	204	21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30	Land Improvements Booked				36,042			(36,042)		30
31	Building Booked				83,732			(83,732)		31
32	Building Improvement Booked				5,833			(5,833)		32
33										33
34	2013-Home Office Allocation-Building Improvements			16,562			397	397		34
35	2013-Home Office Allocation-Land Improvements			1,546			99	99		35
36										36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number Watseka Rehab & HCC

0046847

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

XI. OWNERSHIP COSTS (continued)

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

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 3,133,962	\$ 125,606		\$ 126,316	\$ 710	\$ 1,098,748	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	\$ 788,155	\$ 76,969	\$ 78,816	\$ 1,847	5-10 yrs.	\$ 692,712	71
72	Current Year Purchases	4,046	434	203	(231)	10 yrs.	203	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			38,006	38,006			74
75	TOTALS	\$ 792,201	\$ 77,402	\$ 117,025	\$ 39,623		\$ 692,915	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	Resident	Bus	2005	\$ 20,000	\$	\$	\$		\$ 20,000	76
77										77
78										78
79										79
80	TOTALS			\$ 20,000	\$	\$	\$		\$ 20,000	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)	\$ 4,066,163	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 203,009	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 243,341	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 40,332	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,811,663	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /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: \$ 30,570 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	Facility	2012 Ford E250 Van	\$ 822.05	\$ 8,221	17
18					18
19					19
20					20
21	TOTAL		\$ 822.05	\$ 8,221	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.

Watseka Rehab & HCC

0046847

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	\$ 19,124
Dishwasher	653
Laundry Equipment	-
Copier	9,765
Home Office Allocation	<u>1,028</u>
	<u><u>30,570</u></u>

Facility Name & ID Number Watseka Rehab & HCC # 0046847 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			Total
		1	2	3	
		Drop-outs	Completed	Contract	
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	10,349	\$ 155,234	\$	10,349	\$ 155,234	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,374	20,609		1,374	20,609	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		9,527	142,908		9,527	142,908	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				105,363		105,363	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Therapy Veterans</u>	10A(3)			99	1,484		99	1,484	12
13	Other (specify):									13
14	TOTAL			\$	21,349	\$ 320,235	\$ 105,363	21,349	\$ 425,598	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 Watseka Rehab & HCC# 0046847Report 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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,026,027	\$ 2,026,027	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>30,805</u>)	859,976	859,976	3
4	Supply Inventory (priced at)	15,231	15,231	4
5	Short-Term Investments			5
6	Prepaid Insurance	43,913	43,913	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Empl Loans & Security Deposits</u>	1,763	1,763	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,946,910	\$ 2,946,910	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	660,629	120,000	13
14	Buildings, at Historical Cost	2,511,949	2,528,511	14
15	Leasehold Improvements, at Historical Cost	64,111	605,451	15
16	Equipment, at Historical Cost	812,202	812,201	16
17	Accumulated Depreciation (book methods)	(1,819,897)	(1,811,663)	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 (spec <u>Goodwill</u>)	257,851	257,851	22
23	Other(specify): <u>PPD Mgmt Fee</u>	61,584	61,584	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,548,429	\$ 2,573,935	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,495,339	\$ 5,520,845	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 605,918	\$ 605,918	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	124,049	124,049	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,449	6,449	31
32	Accrued Real Estate Taxes(Sch.IX-B)	79,620	79,620	32
33	Accrued Interest Payable	9,445	9,445	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	58,646	58,646	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 884,127	\$ 884,127	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,633,411	2,633,411	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Due To Due From</u>	843,220	843,220	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,476,631	\$ 3,476,631	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,360,758	\$ 4,360,758	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,134,581	\$ 1,160,087	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,495,339	\$ 5,520,845	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,006,536	1
2	Restatements (describe):		2
3	Nursing Supplies Purchased after CR was completed	(1,698)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,004,838	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	129,743	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 129,743	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,134,581	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Watseka Rehab & HCC# 0046847Report 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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,521,626	1
2	Discounts and Allowances for all Levels	(372,642)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,148,984	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	522,453	6
7	Oxygen	1,294	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 523,747	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	8,441	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	180,584	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	13,740	20
21	Other Medical Services	18,301	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 221,066	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	21,788	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 21,788	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	6,553	28
28a	Transportation Revenue	29,648	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 36,201	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,951,786	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	781,236	31
32	Health Care	2,224,637	32
33	General Administration	932,014	33
B. Capital Expense			
34	Ownership	432,887	34
C. Ancillary Expense			
35	Special Cost Centers	183,737	35
36	Provider Participation Fee	267,532	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,822,043	40
41	Income before Income Taxes (line 30 minus line 40)**	129,743	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 129,743	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,856,411	44
45	Private Pay - Net Inpatient Revenue	935,989	45
46	Medicare - Net Inpatient Revenue	348,093	46
47	Other-(specify) <u>Veterans -Net Patient Revenue</u>	36,608	47
48	Other-(specify) <u>Charity and Insurance Contractual Allowance</u>	(28,117)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,148,984	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 Watseka Rehab & HCC

0046847

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	\$ 60,903	\$ 29.28	1
2	Assistant Director of Nursing	1,994	1,994	54,609	27.39	2
3	Registered Nurses	5,092	5,212	137,612	26.40	3
4	Licensed Practical Nurses	23,746	24,431	520,840	21.32	4
5	CNAs & Orderlies	58,973	60,387	631,365	10.46	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,930	2,088	30,639	14.67	9
10	Activity Assistants	6,103	6,452	71,355	11.06	10
11	Social Service Workers	2,179	2,219	26,993	12.16	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	29,377	14.12	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,201	15,612	137,013	8.78	15
16	Dishwashers					16
17	Maintenance Workers	2,010	2,076	34,554	16.64	17
18	Housekeepers	14,224	14,987	164,291	10.96	18
19	Laundry	1,252	1,252	10,389	8.30	19
20	Administrator	2,080	2,080	73,000	35.10	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,018	2,186	31,292	14.31	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>See PG20A</u>	9,986	10,506	182,327	17.35	33
34	TOTAL (lines 1 - 33)	150,948	155,642	\$ 2,196,559 *	\$ 14.11	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 6,600	L9, C3	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 7,125	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)	\$ 13,725		49

C. CONTRACT NURSES

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

Watseka Rehab & HCC

0046847

Period Beginning

1/1/2013

Period End

12/31/2013

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reportin g Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	4,047	4,359	103,916	23.21
Alzheimer's Coordinator	2,045	2,045	29,065	14.07
Transportation	3,374	3,474	39,392	11.81
Marketing	520	628	9,954	15.96
TOTAL	<u>9,986</u>	<u>10,506</u>	<u>182,327</u>	

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
<u>Karlie Brown</u>	<u>Administrator</u>	<u>0</u>	<u>\$ 73,000</u>	<u>Workers' Compensation Insurance</u>	<u>\$ 92,780</u>	<u>IDPH License Fee</u>	<u>\$ 1,990</u>	
				<u>Unemployment Compensation Insurance</u>	<u>51,187</u>	<u>Advertising: Employee Recruitment</u>	<u>1,276</u>	
				<u>FICA Taxes</u>	<u>159,102</u>	<u>Health Care Worker Background Check</u>		
				<u>Employee Health Insurance</u>	<u>(25,100)</u>	<u>(Indicate # of checks performed)</u>		
				<u>Employee Meals</u>		<u>Patient Background Checks</u>	<u>561</u>	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Miscellaneous Licenses & Permits</u>	<u>425</u>	
				<u>Employee Relations</u>	<u>4,337</u>	<u>Miscellaneous Dues & Subscriptions</u>	<u>371</u>	
				<u>Employee Retirement</u>	<u>523</u>	<u>Home Office Allocation</u>	<u>930</u>	
				<u>Home Office Allocation</u>	<u>843</u>			
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 73,000	TOTAL (agree to Schedule V, line 22, col.8)			\$ 283,672	
(List each licensed administrator separately.)								
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
<u>Management Fees-See Page 6, Eliminated on P 3, C 7</u>			<u>\$ 317,000</u>				<u>Out-of-State Travel</u>	<u>\$</u>
							<u>In-State Travel</u>	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 317,000				<u>Seminar Expense</u>	
(Attach a copy of any management service agreement)							<u>Home Office Allocation</u>	<u>7</u>
C. Professional Services				TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)	
Vendor/Payee	Type	Amount						
<u>Tungate Law Offices</u>	<u>Legal Fees</u>	<u>\$ 50</u>						
<u>Mediacom</u>	<u>Computer Services</u>	<u>1,238</u>						
<u>Iroquis County Circuit Clerk</u>	<u>Filing Fees</u>	<u>5</u>						
<u>Chapin and Long</u>	<u>Legal Services</u>	<u>4,409</u>						
<u>Levin & Perconti</u>	<u>Legal Settlement</u>	<u>200,000</u>						
<u>Livingston, Barger, Brandt</u>	<u>Legal Services</u>	<u>428</u>						
<u>Honkamp Krueger & Co.</u>	<u>Accounting Services</u>	<u>1,018</u>						
<u>Vermillion County</u>	<u>Filing Fees</u>	<u>49</u>						
TOTAL (agree to Schedule V, line 19, column 3)			\$ 207,197					
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications

**See instructions.

Watseka Rehab & HCC

0046847

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)		207,197
Home Office Allocation		
SmithAmundsen	Legal	870
Cole, Schotz, Meisel	Legal	479
Black, Hedin, Ballard	Legal	43
Medicare	Legal	476
Estate of Dorothy Frolker	Legal	501
Ginoli & Company	Accountants	10490
IC System	Computer Services	1494
Miscellaneous	Computer Services	136
Odessian LLC	Computer Services	68
CCH	Computer Services	20
Lexis-Nexis	Computer Services	8
Ipanema Solutions	Computer Services	18
Macquarie Technology Services	Computer Services	124
Advanced Answers on Demand	Computer Services	6441
TeamViewer	Computer Services	21
Stratus Networks	Computer Services	519
Kemper Technology	Computer Services	401
AT&T	Computer Services	7
Medifax	Computer Services	58
Vision Share/Ability Network	Computer Services	882
Barracuda	Computer Services	159
CIAN	Computer Services	212
Comcast	Computer Services	47
Emdeon	Computer Services	71
Marotta Gund Budd & Dzera	Other Prof Fees	1971

David Budde	Other Prof Fees	41
Pharmacy Price Mangement	Other Prof Fees	163
All Scripts	Other Prof Fees	290
Pinnacle Actuarial Resources	Other Prof Fees	2168
Healthlink	Other Prof Fees	53

Total (agree to Schedule V, line 19, column 8)		<u><u>235,428</u></u>
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**Watseka Rehabilitation & Health Care Center
0046847**

Period Beginning 1/1/2011
Period End 12/31/2011

Schedule 21B

XIX. SUPPORT SCHEDULE

Legal Fees

Facility

Vendor/Payee	Invoice Total	Allocation %	Total
Chapin & Long, P.C.	3,761.90	100%	3,762
Livingston, Barger, Brandt & Schroeder	428.00	100%	428
Iroquois County Circuit Clerk	5.00	100%	5
Chapin & Long, P.C.	647.50	100%	648
Levin & Perconti	100,000.00	100%	100,000
Tungate Law Offices, LTD	50.00	100%	50
Vermillion County Recorder	49.00	100%	49
Levin & Perconti	100,000.00	100%	100,000
		100%	-

Home Office Allocation

SmithAmundsen	38,549.00	2.26%	870
Cole, Schotz, Meisel	21,229.00	2.26%	479
Black, Hedin, Ballard	1,919.00	2.26%	43
Medicare	2,187.96	21.76%	476
Estate of Dorothy Frolker and Yandle Law	2,303.07	21.76%	501

Total Legal Fees

207,311

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 Watseka Rehab & HCC# 0046847

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. \$ 35,988 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. \$ 267,532
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. \$ 8,441
- (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. \$ 29,648
- 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? Yes
Attach invoices and a summary of services for all architect and appraisal fees.