		FOR BHF USE					

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

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

I. IDPH License ID Number: 0050344

Facility Name: Westside Rehab & Care Center

Address: 601 North Columbia (Number) West Frankfort (City) 62896 (Zip Code)

County: Franklin

Telephone Number: (618) 932-2109 **Fax #** (618) 937-3289

HFS ID Number:

Date of Initial License for Current Owners: 3/1/2009

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"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:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2013 to 12/31/2013 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

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

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Westside Rehab & Care Center # 0050344 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 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	96	Skilled (SNF)	96	35,040	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	96	TOTALS	96	35,040	7

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	10,584	6,026	1,990	18,600	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,584	6,026	1,990	18,600	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 53.08%

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 3/1/2009

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 3/1/2009 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 40 and days of care provided 1,937

Medicare Intermediary Wisconsin Physicians Service

IV. ACCOUNTING BASIS

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

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 Westside Rehab & Care Center # 0050344 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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	101,098	6,623	3,603	111,324		111,324	3,665	114,989			1
2	Food Purchase		100,175		100,175		100,175	(2,556)	97,619			2
3	Housekeeping	58,020	13,341		71,361		71,361	36	71,397			3
4	Laundry	24,941	3,423		28,364		28,364		28,364			4
5	Heat and Other Utilities			47,862	47,862		47,862	278	48,140			5
6	Maintenance	32,836	7,632	10,694	51,162		51,162	1,795	52,957			6
7	Other (specify):* Home Off. Ben. All.							207	207			7
8	**TOTAL General Services**	216,895	131,194	62,159	410,248		410,248	3,425	413,673			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	689,919	71,195	10,104	771,218		771,218	(487)	770,731			10
10a	Therapy		15	198,877	198,892		198,892		198,892			10a
11	Activities	33,751	141	581	34,473		34,473	(7,856)	26,617			11
12	Social Services	33,045			33,045		33,045		33,045			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Off. Ben. All.											15
16	**TOTAL Health Care and Programs**	756,715	71,351	221,562	1,049,628		1,049,628	(8,343)	1,041,285			16
	C. General Administration											
17	Administrative			204,000	204,000		204,000	(149,000)	55,000			17
18	Directors Fees											18
19	Professional Services			3,279	3,279		3,279	7,727	11,006			19
20	Dues, Fees, Subscriptions & Promotions			5,735	5,735		5,735	341	6,076			20
21	Clerical & General Office Expenses	20,082	1,285	15,442	36,809		36,809	45,351	82,160			21
22	Employee Benefits & Payroll Taxes			154,166	154,166		154,166		154,166			22
23	Inservice Training & Education							73	73			23
24	Travel and Seminar							4	4			24
25	Other Admin. Staff Transportation			4,814	4,814		4,814	3,393	8,207			25
26	Insurance-Prop.Liab.Malpractice			35,508	35,508		35,508	655	36,163			26
27	Other (specify):* Home Off. Ben. All.							4,204	4,204			27
28	**TOTAL General Administration**	20,082	1,285	422,944	444,311		444,311	(87,252)	357,059			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	993,692	203,830	706,665	1,904,187		1,904,187	(92,170)	1,812,017			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 Westside Rehab & Care Center #0050344 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			3,166	3,166		3,166	83,179	86,345			30
31	Amortization of Pre-Op. & Org.							21,742	21,742			31
32	Interest			10,385	10,385		10,385	45,151	55,536			32
33	Real Estate Taxes							24,882	24,882			33
34	Rent-Facility & Grounds			117,172	117,172		117,172	(117,172)				34
35	Rent-Equipment & Vehicles			5,386	5,386		5,386	543	5,929			35
36	Other (specify):*											36
37	**TOTAL Ownership**			136,109	136,109		136,109	58,325	194,434			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		52,668		52,668		52,668		52,668			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			153,152	153,152		153,152		153,152			42
43	Other (specify):* Non-allowable Costs		200	72,076	72,276		72,276	(72,276)				43
44	**TOTAL Special Cost Centers**		52,868	225,228	278,096		278,096	(72,276)	205,820			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	993,692	256,698	1,068,002	2,318,392		2,318,392	(106,121)	2,212,271			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 Westside Rehab & Care Center # 0050344 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.)**

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,634)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,533)	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	(12,403)	30		9
10	Interest and Other Investment Income	(7,696)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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	(17,344)	43		18
19	Entertainment				19
20	Contributions	(125)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(32,010)	43		24
25	Fund Raising, Advertising and Promotional	(851)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(26,991)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (103,587)		$	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 Amount	2 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)	(2,534)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (2,534)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (106,121)		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 Yes	2 No	3 Amount	4 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

STATE OF ILLINOIS

Westside Rehab & Care Center

ID# **0050344**

Report Period Beginning: **1/1/2013**

Ending: **12/31/2013**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs-Part A	$ (6,702)	43	1
2	X-Rays-Part A	(11,528)	43	2
3	Disallowed Special Events	(90)	43	3
4	Offset Miscellaneous Office Supplies Revenue	(72)	21	4
5	Pet Expense	(93)	43	5
6	Offset Transportation Revenue	(7,856)	11	6
7	Disallowed Chamber of Commerce Dues	(150)	43	7
8	Offset Miscellaneous Nursing Supplies Revenue	(500)	10	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**	(26,991)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Westside Rehab & Care Center # 0050344 **Report Period Beginning:** 1/1/2013 **Ending:** 12/31/2013

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	3,665	0	0	0	0	0	0	0	0	0	3,665	1
2	Food Purchase	0	78	0	0	0	0	0	0	0	0	0	78	2
3	Housekeeping	0	36	0	0	0	0	0	0	0	0	0	36	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	278	0	0	0	0	0	0	0	0	0	278	5
6	Maintenance	0	1,795	0	0	0	0	0	0	0	0	0	1,795	6
7	Other (specify):*	0	207	0	0	0	0	0	0	0	0	0	207	7
8	**TOTAL General Services**	0	6,059	0	0	0	0	0	0	0	0	0	6,059	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	(500)	13	0	0	0	0	0	0	0	0	0	(487)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(7,856)	0	0	0	0	0	0	0	0	0	0	(7,856)	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**	(8,356)	13	0	0	0	0	0	0	0	0	0	(8,343)	16
	C. General Administration													
17	Administrative	0	(149,000)	0	0	0	0	0	0	0	0	0	(149,000)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	7,727	0	0	0	0	0	0	0	0	0	7,727	19
20	Fees, Subscriptions & Promotions	0	0	491	0	0	0	0	0	0	0	0	491	20
21	Clerical & General Office Expenses	(72)	0	45,423	0	0	0	0	0	0	0	0	45,351	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	73	0	0	0	0	0	0	0	0	73	23
24	Travel and Seminar	0	0	4	0	0	0	0	0	0	0	0	4	24
25	Other Admin. Staff Transportation	0	0	3,393	0	0	0	0	0	0	0	0	3,393	25
26	Insurance-Prop.Liab.Malpractice	0	0	655	0	0	0	0	0	0	0	0	655	26
27	Other (specify):*	0	0	4,204	0	0	0	0	0	0	0	0	4,204	27
28	**TOTAL General Administration**	(72)	(141,273)	54,243	0	0	0	0	0	0	0	0	(87,102)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(8,428)	(135,201)	54,243	0	0	0	0	0	0	0	0	(89,386)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Westside Rehab & Care Center **#** 0050344 **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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(3,533)	0	3,011	92,571	0	0	0	0	0	0	0	92,049	30
31	Amortization of Pre-Op. & Org.	0	0	0	21,742	0	0	0	0	0	0	0	21,742	31
32	Interest	0	0	5,009	47,838	0	0	0	0	0	0	0	52,847	32
33	Real Estate Taxes	0	0	295	24,587	0	0	0	0	0	0	0	24,882	33
34	Rent-Facility & Grounds	0	0	0	(117,172)	0	0	0	0	0	0	0	(117,172)	34
35	Rent-Equipment & Vehicles	0	0	543	0	0	0	0	0	0	0	0	543	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(3,533)	0	8,858	69,566	0	0	0	0	0	0	0	74,891	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):*	(18,688)	0	0	0	0	0	0	0	0	0	0	(18,688)	43
44	**TOTAL Special Cost Centers**	(18,688)	0	0	0	0	0	0	0	0	0	0	(18,688)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(30,649)	(135,201)	63,101	69,566	0	0	0	0	0	0	0	(33,183)	45

Facility Name & ID Number Westside Rehab & Care Center # 0050344 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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. [X] 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%	$ 3,665	$ 3,665	1
2	V	2	Food		Petersen Health Care, Inc.	100.00%	78	78	2
3	V	3	Housekeeping		Petersen Health Care, Inc.	100.00%	36	36	3
4	V	4	Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5	Utilities		Petersen Health Care, Inc.	100.00%	278	278	5
6	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	1,795	1,795	6
7	V	7	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	207	207	7
8	V	10	Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	13	13	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	204,000	Petersen Health Care, Inc.	100.00%	55,000	(149,000)	11
12	V	19	Professional Services		Petersen Health Care, Inc.	100.00%	7,727	7,727	12
13	V								13
14	Total			$ 204,000			$ 68,799	$ * (135,201)	14

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

Facility Name & ID Number Westside Rehab & Care Center # 0050344 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. [X] 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)	
15	V	20	Dues, Fees, Subs & Promotions	$	Petersen Health Care, Inc.	100.00%	$ 491	$ 491	15
16	V	21	Clerical and General Office		Petersen Health Care, Inc.	100.00%	45,423	45,423	16
17	V	23	Inservice Training & Education		Petersen Health Care, Inc.	100.00%	73	73	17
18	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	4	4	18
19	V	25	Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	3,393	3,393	19
20	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	655	655	20
21	V	27	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	4,204	4,204	21
22	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	3,011	3,011	22
23	V	32	Interest		Petersen Health Care, Inc.	100.00%	5,009	5,009	23
24	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	295	295	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%	543	543	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			$			$ 63,101	$ * 63,101	39

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

Facility Name & ID Number Westside Rehab & Care Center # 0050344 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. [X] 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)	
15	V	30	Depreciation	$	Petersen West Frankfort, LLC	100.00%	$ 92,571	$ 92,571	15
16	V	31	Amortization		Petersen West Frankfort, LLC	100.00%	21,742	21,742	16
17	V	32	Interest		Petersen West Frankfort, LLC	100.00%	47,838	47,838	17
18	V	33	Real Estate Taxes		Petersen West Frankfort, LLC	100.00%	24,587	24,587	18
19	V	21	Clerical and General Office		Petersen West Frankfort, LLC	100.00%	0		19
20	V	34	Rent-Facility and Grounds	117,172	Petersen West Frankfort, LLC	100.00%	0	(117,172)	20
21	V					100.00%	0		21
22	V					100.00%	0		22
23	V					100.00%	0		23
24	V					100.00%	0		24
25	V					100.00%	0		25
26	V					100.00%	0		26
27	V					100.00%	0		27
28	V					100.00%	0		28
29	V					100.00%	0		29
30	V					100.00%	0		30
31	V					100.00%	0		31
32	V					100.00%	0		32
33	V					100.00%	0		33
34	V					100.00%	0		34
35	V					100.00%	0		35
36	V					100.00%	0		36
37	V					100.00%	0		37
38	V					100.00%	0		38
39	Total			$ 117,172			$ 186,738	$ * 69,566	39

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

Facility Name & ID Number Westside Rehab & Care Center # 0050344 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, L	Peoria	Mgmt/Bookkeeping	1
2			Arcola Health Care Center	Arcola	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	2
3			Aspen Rehab & Health Care	Silvis	Petersen Health Care,	Peoria	Mgmt/Bookkeeping	3
4			Batavia Rehab & Health Care Center	Batavia	Petersen Health Enter	Peoria	Mgmt/Bookkeeping	4
5			Bement Health Care Center	Bement	Petersen Health Opera	Peoria	Mgmt/Bookkeeping	5
6			Benton Rehab & Health Care Center	Benton	Petersen Health Syster	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 I	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 Frankfo	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 Ca	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 Westside Rehab & Care Center # 0050344 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

VII. RELATED PARTIES

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

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

Facility Name & ID Number Westside Rehab & Care Center # 0050344 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 Westside Rehab & Care Center # 0050344 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 Westside Rehab & Care Center # 0050344 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	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
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 Westside Rehab & Care Center # 0050344 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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated 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	
1	1	Dietary	Resident Days	1,560,986	75	$ 307,592	$ 295,212	18,600	$ 3,665	1
2	2	Food	Resident Days	1,560,986	75	6,577	0	18,600	78	2
3	3	Housekeeping	Resident Days	1,560,986	75	3,057	0	18,600	36	3
4	4	Laundry	Resident Days	1,560,986	75	0	0	18,600	0	4
5	5	Utilities	Resident Days	1,560,986	75	23,338	0	18,600	278	5
6	6	Maintenance	Resident Days	1,560,986	75	150,672	97,358	18,600	1,795	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,560,986	75	17,394	0	18,600	207	7
8	10	Nursing and Medical Records	Resident Days	1,560,986	75	1,082	0	18,600	13	8
9	10A	Therapy	Resident Days	1,560,986	75	0	0	18,600	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,560,986	75	0	0	18,600	0	10
11	17	Administrative	Resident Days	1,560,986	75	4,578,456	4,578,456	18,600	55,000	11
12	19	Professional Services	Resident Days	1,560,986	75	648,504	0	18,600	7,727	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,560,986	75	41,231	0	18,600	491	13
14	21	Clerical and General Office	Resident Days	1,560,986	75	3,812,055	3,383,297	18,600	45,423	14
15	23	Inservice Training & Education	Resident Days	1,560,986	75	6,148	0	18,600	73	15
16	24	Travel and Seminar	Resident Days	1,560,986	75	313	0	18,600	4	16
17	25	Other Admin. Staff Transport.	Resident Days	1,560,986	75	284,745	0	18,600	3,393	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,560,986	75	54,993	0	18,600	655	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,560,986	75	352,851	0	18,600	4,204	19
20	30	Depreciation	Resident Days	1,560,986	75	252,711	0	18,600	3,011	20
21	32	Interest	Resident Days	1,560,986	75	420,365	0	18,600	5,009	21
22	33	Real Estate Taxes	Resident Days	1,560,986	75	24,742	0	18,600	295	22
23	34	Rent-Facility and Grounds	Resident Days	1,560,986	75	0	0	18,600	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,560,986	75	45,546	0	18,600	543	24
25	TOTALS					$ 11,032,372	$ 8,354,323		$ 131,900	25

Facility Name & ID Number Westside Rehab & Care Center # 0050344 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	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Bank of America		X	Mortgage	Varies	3/1/09	$ 1,312,500	$ 1,105,977	12/31/13	Varies	$ 47,838	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 1,312,500	$ 1,105,977			$ 47,838	9
	B. Non-Facility Related*											
10								Omnicare Inst. Note Payoff			10,385	10
11								Interest Income Offset			(7,696)	11
12								Home Office Allocation-PHC			5,009	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 7,698	14
15	TOTALS (line 9+line14)						$ 1,312,500	$ 1,105,977			$ 55,536	15

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.)**

Facility Name & ID Number Westside Rehab & Care Center **#** 0050344 **Report Period Beginning:** 1/1/2013 **Ending:** 12/31/2013

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 worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 28,224	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	$ 26,015	2
3. Under or (over) accrual (line 2 minus line 1).		$ (2,209)	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 26,796	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.	**Home Office Allocation**	295	
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.		$ 24,882	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2008	26,770	8
	2009	26,683	9
	2010	28,582	10
	2011	27,402	11
	2012	26,015	12

Accrual based on prior year tax bill.

	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

NOTES:

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

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Westside Rehab & Care Center COUNTY Franklin

FACILITY IDPH LICENSE NUMBER 0050344

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

TELEPHONE (309) 691-8113 FAX #: (309) 691-8622

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

Enter the tax index number and real estate tax assessed for 2012 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2012.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-24-105-002	601 N. Columbia, West Frankfort, IL	$ 26,015.48	$ 26,015.48
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 26,015.48	$ 26,015.48

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number Westside Rehab & Care Center # 0050344 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 23,727 B. General Construction Type: Exterior Brick Frame Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 105,084
2. Number of Years Over Which it is Being Amortized: 5
3. Current Period Amortization: 21,742
4. Dates Incurred: 2013

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	17,241	2009	$ 180,000	1
2					2
3	TOTALS	17,241		$ 180,000	3

Facility Name & ID Number Westside Rehab & Care Center # 0050344 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 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	96		2009	1979	$ 1,350,000	$	25	$ 54,000	$ 54,000	$ 243,000	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Roof Repair			2010	2,750		7	392	392	1,372	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	Land Improvements Booked										30
31	Building Booked					54,000			(54,000)		31
32	Building Improvement Booked					393			(393)		32
33											33
34	2013-Home Office Allocation-Building Improvements				8,746			210	210		34
35	2013-Home Office Allocation-Land Improvements				816			52	52		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 Westside Rehab & Care Center # 0050344 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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 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	Land Improvements Booked								63
64	Building Booked								64
65	Building Improvement Booked								65
66									66
67	2013-Home Office Allocation-Building Improvements								67
68	2013-Home Office Allocation-Land Improvements								68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,362,312	$ 54,393		$ 54,654	$ 261	$ 244,372	70

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

Facility Name & ID Number Westside Rehab & Care Center # 0050344 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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	$ 289,412	$ 41,344	$ 28,942	$ (12,402)	5-10 yrs.	$ 128,491	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Home Office Allocation			2,749	2,749			74
75	TOTALS	$ 289,412	$ 41,344	$ 31,691	$ (9,653)		$ 128,491	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,831,724	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 95,737	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 86,345	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (9,392)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 372,863	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Westside Rehab & Care Center # 0050344 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

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

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: *

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	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO

16. Rental Amount for movable equipment: $ 5,929 Description: See Attached Schedule 14A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Westside Rehab & Care Center
0050344
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	$	3,364
Dishwasher		713
Laundry Equipment		-
Copier		1,309
Home Office Allocation		543
		5,929

Facility Name & ID Number Westside Rehab & Care Center # 0050344 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.)

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 PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Westside Rehab & Care Center # 0050344 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A(3)	hrs	$	4,281	$ 64,211	$	4,281	$ 64,211	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2,526	37,894		2,526	37,894	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3), 10A(2)	hrs		6,451	96,772	15	6,451	96,787	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 prescrpts				52,668		52,668	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$	13,258	$ 198,877	$ 52,683	13,258	$ 251,560	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.

STATE OF ILLINOIS

Facility Name & ID Number Westside Rehab & Care Center # 0050344 **Report 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	$ 59,831	$ 59,831	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 54,181)	270,245	270,245	3
4	Supply Inventory (priced at)	6,808	6,808	4
5	Short-Term Investments			5
6	Prepaid Insurance	33,654	33,654	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Security Deposit	50	50	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 370,588	$ 370,588	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		180,000	13
14	Buildings, at Historical Cost		1,358,746	14
15	Leasehold Improvements, at Historical Cost	2,750	3,566	15
16	Equipment, at Historical Cost	19,412	289,412	16
17	Accumulated Depreciation (book methods)	(11,261)	(372,863)	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): Intercompany Loans	71,916	71,916	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 82,817	$ 1,530,777	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 453,405	$ 1,901,365	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 492,244	$ 492,244	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	68,570	68,570	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,187	8,187	31
32	Accrued Real Estate Taxes(Sch.IX-B)		26,796	32
33	Accrued Interest Payable		3,970	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	36,511	36,511	36
37	Accrued Management Fees	288,889	288,889	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 894,401	$ 925,167	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,105,977	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Due To Related Parties		536,084	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 1,642,061	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 894,401	$ 2,567,228	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (440,996)	$ (665,863)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 453,405	$ 1,901,365	48

***(See instructions.)**

Facility Name & ID Number Westside Rehab & Care Center # 0050344 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (433,874)	1
2	Restatements (describe):		2
3	**Rounding**	1	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (433,873)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(7,123)	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)**	$ (7,123)	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)**	$ (440,996)	24 *

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

Facility Name & ID Number Westside Rehab & Care Center # 0050344 Report Period Beginning: 1/1/2013 Ending: 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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,051,555	1
2	Discounts and Allowances for all Levels	(215,865)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,835,690	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	342,556	6
7	Oxygen	172	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 342,728	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	2,634	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	88,980	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	22,540	20
21	Other Medical Services	2,573	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 116,727	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	7,696	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 7,696	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	572	28
28a	Transportation Revenue	7,856	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 8,428	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,311,269	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	410,248	31
32	Health Care	1,049,628	32
33	General Administration	444,311	33
	B. Capital Expense		
34	Ownership	136,109	34
	C. Ancillary Expense		
35	Special Cost Centers	124,944	35
36	Provider Participation Fee	153,152	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,318,392	40
41	**Income before Income Taxes (line 30 minus line 40)****	(7,123)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (7,123)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 912,858	44
45	Private Pay - Net Inpatient Revenue	555,440	45
46	Medicare - Net Inpatient Revenue	372,573	46
47	Other-(specify)		47
48	Other-(specify) Charity Contractual Allowance	(5,181)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 1,835,690	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 Westside Rehab & Care Center # 0050344 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 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,080	$ 67,463	$ 32.43	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,090	3,178	62,429	19.64	3
4	Licensed Practical Nurses	12,537	12,882	219,053	17.00	4
5	CNAs & Orderlies	32,334	32,957	302,395	9.18	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,658	1,695	16,295	9.61	9
10	Activity Assistants					10
11	Social Service Workers	2,080	2,080	33,045	15.89	11
12	Dietician					12
13	Food Service Supervisor	1,726	1,838	16,610	9.04	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,532	9,831	84,488	8.59	15
16	Dishwashers					16
17	Maintenance Workers	2,080	2,080	32,836	15.79	17
18	Housekeepers	6,494	6,667	58,020	8.70	18
19	Laundry	2,806	2,875	24,941	8.68	19
20	Administrator	2,080	2,080	55,000	26.44	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,413	1,477	20,082	13.60	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: CPC	2,080	2,080	38,579	18.55	32
33	Other(specify) Transportation	1,668	1,779	17,456	9.81	33
34	TOTAL (lines 1 - 33)	83,658	85,579	$ 1,048,692 *	$ 12.25	34

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

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 3,603	L1, C3	35
36	Medical Director	Monthly	12,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,046	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)		$ 17,649		49

C. CONTRACT NURSES

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

Facility Name & ID Number Westside Rehab & Care Center # 0050344 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Chris Ely	Administrator	0	$ 55,000
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 55,000

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 204,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 204,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Honkamp Kruger & Co.	Accounting Fees	1,116
Illinois Secretary of State	Filing Fees	350
Mediacom	Computer Services	1,795
Peoria County Recorder of Deeds	Filing Fees	18
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 3,279

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 41,572
Unemployment Compensation Insurance	45,845
FICA Taxes	69,977
Employee Health Insurance	(3,678)
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	450
TOTAL (agree to Schedule V, line 22, col.8)	$ 154,166

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

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks 128	1,281
Miscellaneous Licenses & Permits	258
Miscellaneous Dues & Subscriptions	216
Home Office Allocation	491
Less: Public Relations Expense	(150)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,076

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Home Office Allocation	4
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4

* Attach copy of IMRF notifications

**See instructions.

Westside Rehab & Care Center
0050344
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)		3,279
Home Office Allocation		
SmithAmundsen	Legal	459
Cole, Schotz, Meisel	Legal	253
Black, Hedin, Ballard	Legal	23
Ginoli & Company	Accountants	837
Miscellaneous	Computer Services	70
Odessian LLC	Computer Services	36
CCH	Computer Services	11
Lexis-Nexis	Computer Services	4
Ipanema Solutions	Computer Services	10
Macquarie Technology Services	Computer Services	65
Advanced Answers on Demand	Computer Services	3401
TeamViewer	Computer Services	11
Stratus Networks	Computer Services	274
Kemper Technology	Computer Services	212
AT&T	Computer Services	4
Medifax	Computer Services	31
Vision Share/Ability Network	Computer Services	466
Barracuda	Computer Services	84
CIAN	Computer Services	112
Comcast	Computer Services	25
Emdeon	Computer Services	37
Marotta Gund Budd & Dzera	Other Prof Fees	1041
David Budde	Other Prof Fees	22
Pharmacy Price Mangement	Other Prof Fees	86
All Scripts	Other Prof Fees	153
Total (agree to Schedule V, line 19, column 8)		11,006

Facility Name & ID Number Westside Rehab & Care Center # 0050344 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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	Amount of Expense Amortized Per Year								
					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 Westside Rehab & Care Center # 0050344 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. $ **13,740** 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. $ **153,152**
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. $ **2,634**

(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. $ **7,856**
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.