

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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

<p>I. IDPH License ID Number: <u>0047464</u></p> <p>Facility Name: <u>Enfield Rehabilitation & Health Care Center</u></p> <p>Address: <u>408 North Wilson Street</u> <u>Enfield</u> <u>62835</u> Number City Zip Code</p> <p>County: <u>White</u></p> <p>Telephone Number: <u>(618) 963-2331</u> Fax # <u>(618) 963-2083</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>10/01/2005</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Mike Kocher</u> Telephone Number: <u>(309)689-5850</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2012</u> to <u>12/31/2012</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Type or Print Name) <u>Mark B. Petersen</u> (Title) <u>Chief Executive Officer</u></td> </tr> <tr> <td style="width:15%; padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____</td> </tr> </table> <p align="right">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</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Mark B. Petersen</u> (Title) <u>Chief Executive Officer</u>	Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Mark B. Petersen</u> (Title) <u>Chief Executive Officer</u>							
Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) () _____ Fax # () _____							

Facility Name & ID Number Enfield Rehabilitation & Health Care Center

0047464 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	49	Intermediate (ICF)	49	17,885	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	49	TOTALS	49	17,885	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	
8	SNF				8
9	SNF/PED				9
10	ICF	7,993	370		8,363
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	7,993	370		8,363

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 46.76%

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 10/1/2005

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

YES Date 10/1/2005 NO

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

YES NO If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

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	88,556	7,889	5,430	101,875		101,875	1,522	103,397		1
2	Food Purchase		55,706		55,706		55,706	(890)	54,816		2
3	Housekeeping	52,048	10,878		62,926		62,926	12	62,938		3
4	Laundry		3,056		3,056		3,056	2	3,058		4
5	Heat and Other Utilities			33,668	33,668		33,668	120	33,788		5
6	Maintenance	22,141	4,942	12,952	40,035		40,035	845	40,880		6
7	Other (specify):* Home Off. Ben. All.							203	203		7
8	TOTAL General Services	162,745	82,471	52,050	297,266		297,266	1,814	299,080		8
	B. Health Care and Programs										
9	Medical Director			4,200	4,200		4,200		4,200		9
10	Nursing and Medical Records	392,200	33,503	1,592	427,295		427,295	15	427,310		10
10a	Therapy		(17)		(17)		(17)		(17)		10a
11	Activities	16,627	106	16	16,749		16,749	(7,778)	8,971		11
12	Social Services	21,576			21,576		21,576		21,576		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.										15
16	TOTAL Health Care and Programs	430,403	33,592	5,808	469,803		469,803	(7,763)	462,040		16
	C. General Administration										
17	Administrative			104,600	104,600		104,600	(81,579)	23,021		17
18	Directors Fees										18
19	Professional Services			2,359	2,359		2,359	35,592	37,951		19
20	Dues, Fees, Subscriptions & Promotions			699	699		699	135	834		20
21	Clerical & General Office Expenses	3,225	2,077	10,968	16,270		16,270	17,685	33,955		21
22	Employee Benefits & Payroll Taxes			86,292	86,292		86,292		86,292		22
23	Inservice Training & Education							29	29		23
24	Travel and Seminar							3	3		24
25	Other Admin. Staff Transportation			5,802	5,802		5,802	1,993	7,795		25
26	Insurance-Prop.Liab.Malpractice			15,593	15,593		15,593	325	15,918		26
27	Other (specify):* Home Off. Ben. All.							4,065	4,065		27
28	TOTAL General Administration	3,225	2,077	226,313	231,615		231,615	(21,752)	209,863		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	596,373	118,140	284,171	998,684		998,684	(27,701)	970,983		29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 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			22,145	22,145		22,145	(874)	21,271			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			15,538	15,538		15,538	23,467	39,005			32
33	Real Estate Taxes			6,597	6,597		6,597	215	6,812			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			17,765	17,765		17,765	237	18,002			35
36	Other (specify):*											36
37	TOTAL Ownership			62,045	62,045		62,045	23,045	85,090			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		356		356		356		356			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			115,527	115,527		115,527		115,527			42
43	Other (specify):* Non-allowable Costs		1,146	10,371	11,517		11,517	(11,517)				43
44	TOTAL Special Cost Centers		1,502	125,898	127,400		127,400	(11,517)	115,883			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	596,373	119,642	472,114	1,188,129		1,188,129	(16,173)	1,171,956			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 Enfield Rehabilitation & Health Care Center

0047464

Report Period Beginning: 1/1/2012

Ending: 12/31/2012

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	(941)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,797)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(2,373)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(66)	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	(4,834)	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	47	43		24
25	Fund Raising, Advertising and Promotional	(2,210)	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	(8,447)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (22,621)		\$	30

BHF USE ONLY						
48		49		50		51
						52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	6,448	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 6,448		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (16,173)		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

Enfield Rehabilitation & Health Care Center

ID# 0047464

Report Period Beginning: 1/1/2012

Ending: 12/31/2012

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Offset Miscellaneous Office Supplies Revenue	\$ (12)	21	1
2	Resident Flowers	(133)	43	2
3	Offset Transportation Revenue	(7,778)	11	3
4	Disallow Special events	(192)	43	4
5	X-Rays Part A	(332)	43	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
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		(8,447)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Enfield Rehabilitation & Health Care Center# 0047464

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

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	1,522	0	0	0	0	0	0	0	0	0	1,522	1
2	Food Purchase	(941)	51	0	0	0	0	0	0	0	0	0	(890)	2
3	Housekeeping	0	12	0	0	0	0	0	0	0	0	0	12	3
4	Laundry	0	2	0	0	0	0	0	0	0	0	0	2	4
5	Heat and Other Utilities	0	120	0	0	0	0	0	0	0	0	0	120	5
6	Maintenance	0	845	0	0	0	0	0	0	0	0	0	845	6
7	Other (specify):*	0	203	0	0	0	0	0	0	0	0	0	203	7
8	TOTAL General Services	(941)	2,755	0	0	0	0	0	0	0	0	0	1,814	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	0	15	0	0	0	0	0	0	0	0	0	15	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(7,778)	0	0	0	0	0	0	0	0	0	0	(7,778)	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	(7,778)	15	0	0	0	0	0	0	0	0	0	(7,763)	16
	C. General Administration													
17	Administrative	0	(81,579)	0	0	0	0	0	0	0	0	0	(81,579)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	8,224	0	27,368	0	0	0	0	0	0	0	35,592	19
20	Fees, Subscriptions & Promotions	0	0	117	18	0	0	0	0	0	0	0	135	20
21	Clerical & General Office Expenses	(12)	0	17,233	464	0	0	0	0	0	0	0	17,685	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	29	0	0	0	0	0	0	0	0	29	23
24	Travel and Seminar	0	0	3	0	0	0	0	0	0	0	0	3	24
25	Other Admin. Staff Transportation	0	0	1,975	18	0	0	0	0	0	0	0	1,993	25
26	Insurance-Prop.Liab.Malpractice	0	0	325	0	0	0	0	0	0	0	0	325	26
27	Other (specify):*	0	0	4,065	0	0	0	0	0	0	0	0	4,065	27
28	TOTAL General Administration	(12)	(73,355)	23,747	27,868	0	(21,752)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(8,731)	(70,585)	23,747	27,868	0	(27,701)	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Enfield Rehabilitation & Health Care Center# 0047464

Report Period Beginning:

1/1/2012 Ending:

12/31/2012

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	(2,373)	0	1,463	36	0	0	0	0	0	0	0	(874)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	2,908	20,559	0	0	0	0	0	0	0	23,467	32
33	Real Estate Taxes	0	0	215	0	0	0	0	0	0	0	0	215	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	214	23	0	0	0	0	0	0	0	237	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(2,373)	0	4,800	20,618	0	23,045	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):*	(11,517)	0	0	0	0	0	0	0	0	0	0	(11,517)	43
44	TOTAL Special Cost Centers	(11,517)	0	0	0	0	0	0	0	0	0	0	(11,517)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(22,621)	(70,585)	28,547	48,486	0	0	0	0	0	0	0	(16,173)	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%	\$ 1,522	\$ 1,522	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	51	51	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	12	12	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	2	2	4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	120	120	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	845	845	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	203	203	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	15	15	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	104,600	Petersen Health Care, Inc.	100.00%	23,021	(81,579)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	8,224	8,224	12
13	V							13
14	Total		\$ 104,600			\$ 34,015	\$ * (70,585)	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%	\$ 117	\$	117	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	17,233		17,233	16
17	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	29		29	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	3		3	18
19	V	25 Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	1,975		1,975	19
20	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	325		325	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	4,065		4,065	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	1,463		1,463	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	2,908		2,908	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	215		215	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%	214		214	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		\$			\$ 28,547	\$ *	28,547	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 Dietary	\$	Petersen Health Operations, LLC	100.00%	\$ 0	\$	15
16	V	2 Food		Petersen Health Operations, LLC	100.00%	0		16
17	V	3 Housekeeping		Petersen Health Operations, LLC	100.00%	0		17
18	V	4 Laundry		Petersen Health Operations, LLC	100.00%	0		18
19	V	5 Utilities		Petersen Health Operations, LLC	100.00%	0		19
20	V	6 Maintenance		Petersen Health Operations, LLC	100.00%	0		20
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	0		21
22	V	10 Nursing and Medical Records		Petersen Health Operations, LLC	100.00%	0		22
23	V	12 Social Services		Petersen Health Operations, LLC	100.00%	0		23
24	V	17 Administrative		Petersen Health Operations, LLC	100.00%	0		24
25	V	19 Professional Services		Petersen Health Operations, LLC	100.00%	27,368	27,368	25
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Operations, LLC	100.00%	18	18	26
27	V	21 Clerical and General Office		Petersen Health Operations, LLC	100.00%	464	464	27
28	V	22 Employee Benefits & Payroll		Petersen Health Operations, LLC	100.00%	0		28
29	V	23 Inservice Training & Education		Petersen Health Operations, LLC	100.00%	0		29
30	V	24 Travel and Seminar		Petersen Health Operations, LLC	100.00%	0		30
31	V	25 Other Admin. Staff Transport.		Petersen Health Operations, LLC	100.00%	18	18	31
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Operations, LLC	100.00%	0		32
33	V	27 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	0		33
34	V	30 Depreciation		Petersen Health Operations, LLC	100.00%	36	36	34
35	V	32 Interest		Petersen Health Operations, LLC	100.00%	20,559	20,559	35
36	V	33 Real Estate Taxes		Petersen Health Operations, LLC	100.00%	0		36
37	V	34 Rent-Facility and Grounds		Petersen Health Operations, LLC	100.00%	0		37
38	V	35 Rent-Equipment & Vehicles		Petersen Health Operations, LLC	100.00%	23	23	38
39	Total		\$			\$ 48,486	\$ * 48,486	39

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

Facility Name & ID Number

Enfield Rehabilitation & Health Care Center

0047464

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

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 Enfield Rehabilitation & Health Care Center # 0047464 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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 Enfield Rehabilitation & Health Care Center # 0047464 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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 Enfield Rehabilitation & Health Care Center

0047464

Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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								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 Enfield Rehabilitation & Health Care Cente # 0047464 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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 Enfield Rehabilitation & Health Care Center # 0047464 Report Period Beginning: 1/1/2012 Ending: 2/31/2012

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	1,569,393	74	\$ 285,707	\$ 284,214	8,363	\$ 1,522	1
2	2	Food	Resident Days	1,569,393	74	9,632	0	8,363	51	2
3	3	Housekeeping	Resident Days	1,569,393	74	2,201	0	8,363	12	3
4	4	Laundry	Resident Days	1,569,393	74	397	0	8,363	2	4
5	5	Utilities	Resident Days	1,569,393	74	22,546	0	8,363	120	5
6	6	Maintenance	Resident Days	1,569,393	74	158,485	73,431	8,363	845	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,569,393	74	38,057	0	8,363	203	7
8	10	Nursing and Medical Records	Resident Days	1,569,393	74	2,750	0	8,363	15	8
9	10A	Therapy	Resident Days	1,569,393	74	0	0	8,363	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,569,393	74	0	0	8,363	0	10
11	17	Administrative	Resident Days	1,569,393	74	4,353,655	4,353,655	8,363	23,021	11
12	19	Professional Services	Resident Days	1,569,393	74	1,543,275	0	8,363	8,224	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,569,393	74	21,988	0	8,363	117	13
14	21	Clerical and General Office	Resident Days	1,569,393	74	3,233,970	2,816,787	8,363	17,233	14
15	23	Inservice Training & Education	Resident Days	1,569,393	74	5,397	0	8,363	29	15
16	24	Travel and Seminar	Resident Days	1,569,393	74	535	0	8,363	3	16
17	25	Other Admin. Staff Transport.	Resident Days	1,569,393	74	370,568	0	8,363	1,975	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,569,393	74	61,077	0	8,363	325	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,569,393	74	762,912	0	8,363	4,065	19
20	30	Depreciation	Resident Days	1,569,393	74	274,514	0	8,363	1,463	20
21	32	Interest	Resident Days	1,569,393	74	545,764	0	8,363	2,908	21
22	33	Real Estate Taxes	Resident Days	1,569,393	74	40,424	0	8,363	215	22
23	34	Rent-Facility and Grounds	Resident Days	1,569,393	74	0	0	8,363	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,569,393	74	40,223	0	8,363	214	24
25	TOTALS					\$ 11,774,077	\$ 7,528,087		\$ 62,562	25

Facility Name & ID Number Enfield Rehabilitation & Health Care Center # 0047464 Report Period Beginning: 1/1/2012 Ending: 2/31/2012

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	404,785	21		8,363		1
2	2	Food	Resident Days	404,785	21		8,363		2
3	3	Housekeeping	Resident Days	404,785	21		8,363		3
4	4	Laundry	Resident Days	404,785	21		8,363		4
5	5	Utilities	Resident Days	404,785	21		8,363		5
6	6	Maintenance	Resident Days	404,785	21		8,363		6
7	7	Mgmt. Allocation of Benefits	Resident Days	404,785	21		8,363		7
8	10	Nursing and Medical Records	Resident Days	404,785	21		8,363		8
9	12	Social Services	Resident Days	404,785	21		8,363		9
10	17	Administrative	Resident Days	404,785	21		8,363		10
11	19	Professional Services	Resident Days	404,785	21	1,324,676	8,363	27,368	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	404,785	21	876	8,363	18	12
13	21	Clerical and General Office	Resident Days	404,785	21	22,478	8,363	464	13
14	22	Employee Benefits & Payroll	Resident Days	404,785	21		8,363		14
15	23	Inservice Training & Education	Resident Days	404,785	21		8,363		15
16	24	Travel and Seminar	Resident Days	404,785	21		8,363		16
17	25	Other Admin. Staff Transport.	Resident Days	404,785	21	849	8,363	18	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	404,785	21		8,363		18
19	27	Mgmt. Allocation of Benefits	Resident Days	404,785	21		8,363		19
20	30	Depreciation	Resident Days	404,785	21	1,761	8,363	36	20
21	32	Interest	Resident Days	404,785	21	995,096	8,363	20,559	21
22	33	Real Estate Taxes	Resident Days	404,785	21		8,363		22
23	34	Rent-Facility and Grounds	Resident Days	404,785	21		8,363		23
24	35	Rent-Equipment & Vehicles	Resident Days	404,785	21	1,130	8,363	23	24
25	TOTALS					\$ 2,346,866	\$	\$ 48,486	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	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	Bank of America		X	Mortgage	Varies	1/19/07	\$ 200,000	\$ 186,856	12/31/13	Varies	\$ 15,538	1								
2												2								
3												3								
4												4								
5												5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related						\$ 200,000	\$ 186,856			\$ 15,538	9								
B. Non-Facility Related*																				
10												10								
11												11								
12										Home Office Allocation-PHC	2,908	12								
13										Home Office Allocation-PHO	20,559	13								
14	TOTAL Non-Facility Related						\$	\$			\$ 23,467	14								
15	TOTALS (line 9+line14)						\$ 200,000	\$ 186,856			\$ 39,005	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

* 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 2011 report.			\$	6,720	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.)	2011		\$	6,561	2														
3. Under or (over) accrual (line 2 minus line 1).			\$	(159)	3														
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	6,756	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.				215															
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.			\$	6,812	7														
Real Estate Tax History:																			
Real Estate Tax Bill for Calendar Year:	2007	<u>6,090</u>	8	<table border="1"> <tr> <td colspan="2" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2011 \$</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td style="text-align: center;">16</td> </tr> </table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2011 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
FOR BHF USE ONLY																			
13	FROM R. E. TAX STATEMENT FOR 2011 \$	13																	
14	PLUS APPEAL COST FROM LINE 5 \$	14																	
15	LESS REFUND FROM LINE 6 \$	15																	
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																	
	2008	<u>6,365</u>	9																
	2009	<u>6,099</u>	10																
	2010	<u>6,482</u>	11																
	2011	<u>6,561</u>	12																
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 X 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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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: 10,476 B. General Construction Type: Exterior Brick & Concrete Frame Wood 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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>75,359</u>	<u>2005</u>	<u>\$ 15,750</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	<u>75,359</u>		<u>\$ 15,750</u>	<u>3</u>

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	49	2005	1972	\$ 280,250	\$	25	\$ 11,209	\$ 11,209	\$ 84,069
5									
6									
7									
8									
Improvement Type**									
9	Original Land	2005		10,000		15	667	667	5,002
10	Door Alarm	2007		1,636		15	109	109	600
11	Air Compressor	2007		1,302		15	87	87	478
12	New Roof	2007		29,725		20	1,486	1,486	8,173
13	Awning	2008		2,569		20	128	128	576
14	Sprinkler System	2011		2,990		7	428	428	642
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30	Land Improvements Booked				667			(667)	
31	Building Booked				11,253			(11,253)	
32	Building Improvement Booked				1,388			(1,388)	
33									
34	2012-Home Office Allocation-Building Improvements			3,911			94	94	
35	2012-Home Office Allocation-Land Improvements			365			23	23	
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 Enfield Rehabilitation & Health Care Center

0047464

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

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)		\$ 332,748	\$ 13,308		\$ 14,231	\$ 923	\$ 99,540	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	\$ 85,922	\$ 8,837	\$ 5,658	\$ (3,179)	5-10 yrs.	\$ 71,674	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Home Office Allocation			1,382	1,382			74
75	TOTALS	\$ 85,922	\$ 8,837	\$ 7,040	\$ (1,797)		\$ 71,674	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	N/A									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)	\$ 434,420	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 22,145	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 21,271	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (874)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 171,214	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. _____ /2013 \$ _____

13. _____ /2014 \$ _____

14. _____ /2015 \$ _____

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: \$ 11,064 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	2006 Ford E250	578.16	\$ 6,938	17
18					18
19					19
20					20
21	TOTAL		\$ 578.16	\$ 6,938	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.

Enfield Rehabilitation & Health Care Center

0047464

Period Beginning **1/1/2012**

Period End **12/31/2012**

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$	5,391
Dishwasher		731
Laundry Equipment		4,705
Copier		-
Home Office Allocation		237
		<u>11,064</u>

Facility Name & ID Number Enfield Rehabilitation & Health Care Center # 0047464 Report Period Beginning: 1/1/2012 Ending: 12/31/2012
XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			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	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$			\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2)	hrs							4
5	Physician Care		visits			(17)			(17)	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				356		356	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			\$		\$	339		\$ 339	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 Enfield Rehabilitation & Health Care Center# 0047464Report Period Beginning: 1/1/2012

Ending:

12/31/2012

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2012

(last day of reporting year)

This report must be completed even if f (1,408,534)

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 550	\$ 550	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 4,000)	246,012	246,012	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	15,338	15,338	6
7	Other Prepaid Expenses	5,203	5,203	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 267,103	\$ 267,103	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	25,750	15,750	13
14	Buildings, at Historical Cost	280,250	284,161	14
15	Leasehold Improvements, at Historical Cost	38,222	48,587	15
16	Equipment, at Historical Cost	82,583	85,922	16
17	Accumulated Depreciation (book methods)	(169,179)	(171,214)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 257,626	\$ 263,206	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 524,729	\$ 530,309	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,579,716	\$ 1,579,716	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	14,054	14,054	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,137	10,137	31
32	Accrued Real Estate Taxes(Sch.IX-B)	6,756	6,756	32
33	Accrued Interest Payable	516	516	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	9,395	9,395	36
37	<u>Accrued Management Fees</u>	131,413	131,413	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,751,987	\$ 1,751,987	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	186,856	186,856	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 186,856	\$ 186,856	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,938,843	\$ 1,938,843	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,414,114)	\$ (1,408,534)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 524,729	\$ 530,309	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,159,799)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,159,799)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(254,315)	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)	\$ (254,315)	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)	\$ (1,414,114)	24 *

* This must agree with page 17, line 47.

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	\$ 925,083	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 925,083	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	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	941	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 941	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	12	28
28a	Transportation Revenue	7,778	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 7,790	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 933,814	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	297,266	31
32	Health Care	469,803	32
33	General Administration	231,615	33
B. Capital Expense			
34	Ownership	62,045	34
C. Ancillary Expense			
35	Special Cost Centers	11,873	35
36	Provider Participation Fee	115,527	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,188,129	40
41	Income before Income Taxes (line 30 minus line 40)**	(254,315)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (254,315)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 882,157	44
45	Private Pay - Net Inpatient Revenue	42,926	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 925,083	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No 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 Enfield Rehabilitation & Health Care Center

0047464

Report Period Beginning: 1/1/2012

Ending: 12/31/2012

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	2,057	2,123	\$ 49,681	\$ 23.40	1
2	Assistant Director of Nursing					2
3	Registered Nurses	883	885	17,775	20.08	3
4	Licensed Practical Nurses	8,521	8,722	144,277	16.54	4
5	CNAs & Orderlies	17,086	17,442	180,128	10.33	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	1,310	1,354	11,448	8.45	10
11	Social Service Workers	1,922	2,048	21,576	10.54	11
12	Dietician					12
13	Food Service Supervisor	1,917	2,077	26,126	12.58	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,423	6,692	62,430	9.33	15
16	Dishwashers					16
17	Maintenance Workers	1,837	1,837	22,141	12.05	17
18	Housekeepers	5,842	6,152	52,048	8.46	18
19	Laundry					19
20	Administrator	1,040	1,040	23,021	22.14	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	208	208	3,225	15.50	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: Care Plan Coord	16	16	339	21.19	32
33	Other(specify) <u>Tranportation</u>	618	618	5,179	8.38	33
34	TOTAL (lines 1 - 33)	49,680	51,214	\$ 619,394 *	\$ 12.09	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	108	\$ 5,430	L1, C3	35
36	Medical Director	Monthly	4,200	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,592	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)	108	\$ 11,222		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Loretta Ellis	Administrator	0	\$ 7,596	Workers' Compensation Insurance	\$ 19,079	IDPH License Fee	\$	
Patti Scates	Administrator	0	15,425	Unemployment Compensation Insurance	20,105	Advertising: Employee Recruitment	35	
				FICA Taxes	46,882	Health Care Worker Background Check		
				Employee Health Insurance	(169)	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks	23 236	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	428	
				Employee Relations	395	Home Office Allocation	135	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 23,021					
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
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 104,600				Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 104,600				Seminar Expense	
(Attach a copy of any management service agreement)							Home Office Allocation	3
C. Professional Services				TOTAL			Entertainment Expense	
Vendor/Payee	Type	Amount					(agree to Sch. V,	
Black, Hedin, Ballard	Legal Fees	\$ 630					line 24, col. 8)	
Odessian	Computer Services	225					TOTAL	
E-Health Data Solutions	Computer Services	740					\$ 3	
Frontier	Computer Services	764						
TOTAL (agree to Schedule V, line 19, column 3)								
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 2,359					

* Attach copy of IMRF notifications

**See instructions.

Enfield Rehabilitation & Health Care Center

0047464

Period Beginning 1/1/2012

Period End 12/31/2012

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		2,359

Home Office Allocation

Sorling Northrup	Legal	26
Ginoli & Company	Accountants	936
Miscellaneous	Computer Services	23
Nebo Systems	Computer Services	1
Advanced Answers on Demand	Computer Services	1,271
Access 2 Go	Computer Services	53
Stratus Networks	Computer Services	53
Kemper Technology	Computer Services	87
CCH	Computer Services	5
Medifax	Computer Services	10
Vision Share/Ability Network	Computer Services	97
Barracuda	Computer Services	3
CIAN	Computer Services	26
Comcast	Computer Services	8
Postini	Computer Services	82
Optimizer Systems	Other Prof Fees	13
Marotta Gund Budd & Dzera	Other Prof Fees	32,593
David Budde	Other Prof Fees	5
Courtney Bourban	Other Prof Fees	72
All Scripts	Other Prof Fees	222
Heritage Enterprises	Other Prof Fees	5
Miscellaneous Vendors	Other Prof Fees	1

Total (agree to Schedule V, line 19, column 8)	<u><u>37,951</u></u>
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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 Enfield Rehabilitation & Health Care Center# 0047464

Report Period Beginning:

1/1/2012

Ending:

12/31/2012**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. \$ 4,433 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. \$ 115,527
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. \$ 941
- (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. \$ 7,778
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? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli & Company
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? No
Attach invoices and a summary of services for all architect and appraisal fees.