

		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><b>I. IDPH License ID Number:</b> <u>0050641</u></p> <p><b>Facility Name:</b> <u>Nokomis Rehab &amp; Health Care Center</u></p> <p><b>Address:</b> <u>505 Stevens Street</u> <u>Nokomis</u> <u>62075</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>Montgomery</u></p> <p><b>Telephone Number:</b> <u>217-563-7725</u> <b>Fax #</b> <u>217-563-2022</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>8/1/2007</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT  <input type="checkbox"/> Charitable Corp.  <input type="checkbox"/> Trust            IRS Exemption Code _____         </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY  <input type="checkbox"/> Individual  <input type="checkbox"/> Partnership  <input type="checkbox"/> Corporation  <input type="checkbox"/> "Sub-S" Corp.  <input checked="" type="checkbox"/> Limited Liability Co.  <input type="checkbox"/> Trust  <input type="checkbox"/> Other _____         </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL  <input type="checkbox"/> State  <input type="checkbox"/> County  <input type="checkbox"/> Other _____         </td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Mike Kocher</u> <b>Telephone Number:</b> <u>(309)689-5850</u>  <b>Email Address:</b> _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2012</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) _____            (Print Name and Title) _____            (Firm Name &amp; Address) _____            (Telephone) ( ) _____ Fax # ( ) _____         </td> </tr> </table> <p align="right"> <b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>  <b>201 S. Grand Avenue East</b>  <b>Springfield, IL 62763-0001</b> Phone # (217) 782-1630         </p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Mark B. Petersen</u> (Title) <u>Chief Executive Officer</u>	Paid Preparer	(Signed) _____ (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) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) ( ) _____ Fax # ( ) _____							

Facility Name & ID Number Nokomis Rehab & Health Care Center

# 0050641 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	92	Skilled (SNF)	92	33,580	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	92	TOTALS	92	33,580	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	10,180	4,694	1,525	16,399	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,180	4,694	1,525	16,399	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 48.84%

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 8/1/2007

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

YES  Date 8/1/2007 NO

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

YES  NO  If YES, enter number of beds certified 12 and days of care provided 1,436

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

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

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

Facility Name &amp; ID Number

Nokomis Rehab &amp; Health Care Center

# 0050641

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	113,035	11,871		124,906		124,906	2,985	127,891		1
2	Food Purchase		103,499		103,499		103,499	(4,048)	99,451		2
3	Housekeeping	76,811	14,913		91,724		91,724	23	91,747		3
4	Laundry	43,686	13,533		57,219		57,219	4	57,223		4
5	Heat and Other Utilities			71,900	71,900		71,900	236	72,136		5
6	Maintenance	27,256	5,554	20,224	53,034		53,034	1,847	54,881		6
7	Other (specify):* Home Off. Ben. All.							398	398		7
8	<b>TOTAL General Services</b>	260,788	149,370	92,124	502,282		502,282	1,445	503,727		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			11,000	11,000		11,000		11,000		9
10	Nursing and Medical Records	732,418	56,324	4,292	793,034		793,034	(1,610)	791,424		10
10a	Therapy			147,410	147,410		147,410		147,410		10a
11	Activities	17,717	205	151	18,073		18,073	(10,044)	8,029		11
12	Social Services	30,560			30,560		30,560		30,560		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.										15
16	<b>TOTAL Health Care and Programs</b>	780,695	56,529	162,853	1,000,077		1,000,077	(11,654)	988,423		16
	<b>C. General Administration</b>										
17	Administrative			237,400	237,400		237,400	(172,864)	64,536		17
18	Directors Fees										18
19	Professional Services			3,269	3,269		3,269	18,921	22,190		19
20	Dues, Fees, Subscriptions & Promotions			483	483		483	351	834		20
21	Clerical & General Office Expenses	24,779	2,781	9,767	37,327		37,327	34,724	72,051		21
22	Employee Benefits & Payroll Taxes			162,297	162,297		162,297	544	162,841		22
23	Inservice Training & Education			(65)	(65)		(65)	56	(9)		23
24	Travel and Seminar							6	6		24
25	Other Admin. Staff Transportation			3,444	3,444		3,444	5,715	9,159		25
26	Insurance-Prop.Liab.Malpractice			29,458	29,458		29,458	638	30,096		26
27	Other (specify):* Home Off. Ben. All.							7,972	7,972		27
28	<b>TOTAL General Administration</b>	24,779	2,781	446,053	473,613		473,613	(103,937)	369,676		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,066,262	208,680	701,030	1,975,972		1,975,972	(114,146)	1,861,826		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	
	<b>D. Ownership</b>											
30	Depreciation			74,904	74,904		74,904	(4,044)	70,860			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			119,920	119,920		119,920	28,738	148,658			32
33	Real Estate Taxes			52,802	52,802		52,802	422	53,224			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			10,634	10,634		10,634	517	11,151			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			258,260	258,260		258,260	25,633	283,893			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		47,068		47,068		47,068		47,068			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			207,569	207,569		207,569		207,569			42
43	Other (specify):* <b>Non-allowable Costs</b>			50,920	50,920		50,920	(50,920)				43
44	<b>TOTAL Special Cost Centers</b>		47,068	258,489	305,557		305,557	(50,920)	254,637			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,066,262	255,748	1,217,779	2,539,789		2,539,789	(139,433)	2,400,356			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 Nokomis Rehab & Health Care Center

# 0050641

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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,149)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(7,044)	30		9
10	Interest and Other Investment Income	(283)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(240)	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	(10,604)	43		18
19	Entertainment				19
20	Contributions	(140)	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	(35,063)	43		24
25	Fund Raising, Advertising and Promotional	(1,193)	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	(15,735)	Various		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (74,451)</b>		<b>\$</b>	<b>30</b>

<b>BHF USE ONLY</b>						
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	
		<b>Amount</b>	<b>Reference</b>	
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)	(64,982)	Various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ (64,982)</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (139,433)</b>		<b>37</b>

\*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
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
38	Medically Necessary Transport.		X	\$	38
39					39
40	Gift and Coffee Shops		X		40
41	Barber and Beauty Shops		X		41
42	Laboratory and Radiology		X		42
43	Prescription Drugs		X		43
44					44
45	Other-Attach Schedule		X		45
46	Other-Attach Schedule		X		46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>	<b>47</b>

Nokomis Rehab & Health Care Center

ID# 0050641

Report Period Beginning: 1/1/2012

Ending: 12/31/2012

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Labs-Part A	\$ (2,041)	43	1
2	X-Rays-Part A	(1,387)	43	2
3	Disallowed Special Events	(225)	43	3
4	Disallow Resident Flowers	(27)	43	4
5	Offset Miscellaneous Office Supplies Revenue	(369)	21	5
6	Disallowed Medicare Interest Withholding	(3)	32	6
7	Offset Transportation Revenue	(10,044)	11	7
8	Offset Miscellaneous Nursing Supplies	(1,639)	10	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>		(15,735)	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Nokomis Rehab & Health Care Center# 0050641

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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	0	2,985	0	0	0	0	0	0	0	0	0	2,985	1
2	Food Purchase	(4,149)	101	0	0	0	0	0	0	0	0	0	(4,048)	2
3	Housekeeping	0	23	0	0	0	0	0	0	0	0	0	23	3
4	Laundry	0	4	0	0	0	0	0	0	0	0	0	4	4
5	Heat and Other Utilities	0	236	0	0	0	0	0	0	0	0	0	236	5
6	Maintenance	0	1,656	0	191	0	0	0	0	0	0	0	1,847	6
7	Other (specify):*	0	398	0	0	0	0	0	0	0	0	0	398	7
8	<b>TOTAL General Services</b>	<b>(4,149)</b>	<b>5,403</b>	<b>0</b>	<b>191</b>	<b>0</b>	<b>1,445</b>	<b>8</b>						
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(1,639)	29	0	0	0	0	0	0	0	0	0	(1,610)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(10,044)	0	0	0	0	0	0	0	0	0	0	(10,044)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>(11,683)</b>	<b>29</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(11,654)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(172,864)	0	0	0	0	0	0	0	0	0	(172,864)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	16,126	0	0	0	0	0	0	0	0	0	16,126	19
20	Fees, Subscriptions & Promotions	0	0	230	2,795	0	0	0	0	0	0	0	3,025	20
21	Clerical & General Office Expenses	(369)	0	33,793	121	0	0	0	0	0	0	0	33,545	21
22	Employee Benefits & Payroll Taxes	0	0	0	1,300	0	0	0	0	0	0	0	1,300	22
23	Inservice Training & Education	0	0	56	544	0	0	0	0	0	0	0	600	23
24	Travel and Seminar	0	0	6	0	0	0	0	0	0	0	0	6	24
25	Other Admin. Staff Transportation	0	0	3,872	1,843	0	0	0	0	0	0	0	5,715	25
26	Insurance-Prop.Liab.Malpractice	0	0	638	0	0	0	0	0	0	0	0	638	26
27	Other (specify):*	0	0	7,972	0	0	0	0	0	0	0	0	7,972	27
28	<b>TOTAL General Administration</b>	<b>(369)</b>	<b>(156,738)</b>	<b>46,567</b>	<b>6,603</b>	<b>0</b>	<b>(103,937)</b>	<b>28</b>						
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(16,201)</b>	<b>(151,306)</b>	<b>46,567</b>	<b>6,794</b>	<b>0</b>	<b>(114,146)</b>	<b>29</b>						

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Nokomis Rehab & Health Care Center# 0050641

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)	
	<b>D. Ownership</b>													
30	Depreciation	(7,044)	0	2,868	132	0	0	0	0	0	0	0	(4,044)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(286)	0	5,703	23,321	0	0	0	0	0	0	0	28,738	32
33	Real Estate Taxes	0	0	422	0	0	0	0	0	0	0	0	422	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	420	97	0	0	0	0	0	0	0	517	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(7,330)</b>	<b>0</b>	<b>9,413</b>	<b>23,550</b>	<b>0</b>	<b>25,633</b>	<b>37</b>						
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(50,920)	0	0	0	0	0	0	0	0	0	0	(50,920)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(50,920)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(50,920)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(74,451)	(151,306)	55,980	30,344	0	0	0	0	0	0	0	(139,433)	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%	\$ 2,985	\$ 2,985	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	101	101	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	23	23	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	4	4	4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	236	236	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	1,656	1,656	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	398	398	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	29	29	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	237,400	Petersen Health Care, Inc.	100.00%	64,536	(172,864)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	16,126	16,126	12
13	V							13
14	Total		\$ 237,400			\$ 86,094	\$ * (151,306)	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%	\$ 230	\$	230	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	33,793		33,793	16
17	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	56		56	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	6		6	18
19	V	25 Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	3,872		3,872	19
20	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	638		638	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	7,972		7,972	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	2,868		2,868	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	5,703		5,703	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	422		422	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%	420		420	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		\$			\$ 55,980	\$ *	55,980	39

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

Facility Name & ID Number Nokomis Rehab & Health Care Center# 0050641Report Period Beginning: 1/1/2012Ending: 12/31/2012

## 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 Network, LLC	100.00%	\$ 0	\$	15	
16	V	2 Food		Petersen Health Network, LLC	100.00%	0		16	
17	V	3 Housekeeping		Petersen Health Network, LLC	100.00%	0		17	
18	V	4 Laundry		Petersen Health Network, LLC	100.00%	0		18	
19	V	5 Utilities		Petersen Health Network, LLC	100.00%	0		19	
20	V	6 Maintenance		Petersen Health Network, LLC	100.00%	191	191	20	
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Network, LLC	100.00%	0		21	
22	V	10 Nursing and Medical Records		Petersen Health Network, LLC	100.00%	0		22	
23	V	12 Social Services		Petersen Health Network, LLC	100.00%	0		23	
24	V	17 Administrative		Petersen Health Network, LLC	100.00%	0		24	
25	V	19 Professional Services		Petersen Health Network, LLC	100.00%	0		25	
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Network, LLC	100.00%	2,795	2,795	26	
27	V	21 Clerical and General Office		Petersen Health Network, LLC	100.00%	121	121	27	
28	V	22 Employee Benefits & Payroll		Petersen Health Network, LLC	100.00%	1,300	1,300	28	
29	V	23 Inservice Training & Education		Petersen Health Network, LLC	100.00%	544	544	29	
30	V	24 Travel and Seminar		Petersen Health Network, LLC	100.00%	0		30	
31	V	25 Other Admin. Staff Transport.		Petersen Health Network, LLC	100.00%	1,843	1,843	31	
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Network, LLC	100.00%	0		32	
33	V	27 Mgmt. Allocation of Benefits		Petersen Health Network, LLC	100.00%	0		33	
34	V	30 Depreciation		Petersen Health Network, LLC	100.00%	132	132	34	
35	V	32 Interest		Petersen Health Network, LLC	100.00%	23,321	23,321	35	
36	V	33 Real Estate Taxes		Petersen Health Network, LLC	100.00%	0		36	
37	V	34 Rent-Facility and Grounds		Petersen Health Network, LLC	100.00%	0		37	
38	V	35 Rent-Equipment & Vehicles		Petersen Health Network, LLC	100.00%	97	97	38	
39	Total		\$			\$ 30,344	\$ *	30,344	39

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

Facility Name &amp; ID Number

Nokomis Rehab &amp; Health Care Center

# 0050641

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 &amp; ID Number

Nokomis Rehab &amp; Health Care Center

# 0050641

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 &amp; ID Number

Nokomis Rehab &amp; Health Care Center

# 0050641

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

Nokomis Rehab & Health Care Center

# 0050641

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 Nokomis Rehab & Health Care Center # 0050641 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 Nokomis Rehab & Health Care Center

# 0050641

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	16,399	\$ 2,985	1
2	2	Food	Resident Days	1,569,393	74	9,632	0	16,399	101	2
3	3	Housekeeping	Resident Days	1,569,393	74	2,201	0	16,399	23	3
4	4	Laundry	Resident Days	1,569,393	74	397	0	16,399	4	4
5	5	Utilities	Resident Days	1,569,393	74	22,546	0	16,399	236	5
6	6	Maintenance	Resident Days	1,569,393	74	158,485	73,431	16,399	1,656	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,569,393	74	38,057	0	16,399	398	7
8	10	Nursing and Medical Records	Resident Days	1,569,393	74	2,750	0	16,399	29	8
9	10A	Therapy	Resident Days	1,569,393	74	0	0	16,399	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,569,393	74	0	0	16,399	0	10
11	17	Administrative	Resident Days	1,569,393	74	4,353,655	4,353,655	16,399	64,536	11
12	19	Professional Services	Resident Days	1,569,393	74	1,543,275	0	16,399	16,126	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,569,393	74	21,988	0	16,399	230	13
14	21	Clerical and General Office	Resident Days	1,569,393	74	3,233,970	2,816,787	16,399	33,793	14
15	23	Inservice Training & Education	Resident Days	1,569,393	74	5,397	0	16,399	56	15
16	24	Travel and Seminar	Resident Days	1,569,393	74	535	0	16,399	6	16
17	25	Other Admin. Staff Transport.	Resident Days	1,569,393	74	370,568	0	16,399	3,872	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,569,393	74	61,077	0	16,399	638	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,569,393	74	762,912	0	16,399	7,972	19
20	30	Depreciation	Resident Days	1,569,393	74	274,514	0	16,399	2,868	20
21	32	Interest	Resident Days	1,569,393	74	545,764	0	16,399	5,703	21
22	33	Real Estate Taxes	Resident Days	1,569,393	74	40,424	0	16,399	422	22
23	34	Rent-Facility and Grounds	Resident Days	1,569,393	74	0	0	16,399	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,569,393	74	40,223	0	16,399	420	24
25	TOTALS					\$ 11,774,077	\$ 7,528,087		\$ 142,074	25

Facility Name & ID Number Nokomis Rehab & Health Care Center

# 0050641

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 Network, 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	207,636	12		16,399		1
2	2	Food	Resident Days	207,636	12		16,399		2
3	3	Housekeeping	Resident Days	207,636	12		16,399		3
4	4	Laundry	Resident Days	207,636	12		16,399		4
5	5	Utilities	Resident Days	207,636	12		16,399		5
6	6	Maintenance	Resident Days	207,636	12	2,422	16,399	191	6
7	7	Mgmt. Allocation of Benefits	Resident Days	207,636	12		16,399		7
8	10	Nursing and Medical Records	Resident Days	207,636	12		16,399		8
9	10A	Therapy	Resident Days	207,636	12		16,399		9
10	15	Mgmt. Allocation of Benefits	Resident Days	207,636	12		16,399		10
11	17	Administrative	Resident Days	207,636	12		16,399		11
12	19	Professional Services	Resident Days	207,636	12	35,385	16,399	2,795	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	207,636	12	1,525	16,399	121	13
14	21	Clerical and General Office	Resident Days	207,636	12	16,458	16,399	1,300	14
15	22	Employee Benefits & Payroll	Resident Days	207,636	12	6,884	16,399	544	15
16	24	Travel and Seminar	Resident Days	207,636	12		16,399		16
17	25	Other Admin. Staff Transport.	Resident Days	207,636	12	23,340	16,399	1,843	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	207,636	12		16,399		18
19	27	Mgmt. Allocation of Benefits	Resident Days	207,636	12		16,399		19
20	30	Depreciation	Resident Days	207,636	12	1,668	16,399	132	20
21	32	Interest	Resident Days	207,636	12	295,279	16,399	23,321	21
22	33	Real Estate Taxes	Resident Days	207,636	12		16,399		22
23	34	Rent-Facility and Grounds	Resident Days	207,636	12		16,399		23
24	35	Rent-Equipment & Vehicles	Resident Days	207,636	12	1,227	16,399	97	24
25	TOTALS					\$ 384,188	\$	\$ 30,344	25

Facility Name & ID Number Nokomis Rehab & Health Care Center

# 0050641

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
<b>A. Directly Facility Related</b>																	
<b>Long-Term</b>																	
1	The Private Bank		X	Mortgage	Varies	11/1/09	1,711,060	\$ 1,619,248	12/31/14	Varies	\$ 119,917	1					
2												2					
3												3					
4												4					
5												5					
<b>Working Capital</b>																	
6												6					
7												7					
8												8					
9	<b>TOTAL Facility Related</b>						\$ 1,711,060	\$ 1,619,248			\$ 119,917	9					
<b>B. Non-Facility Related*</b>																	
10												10					
11										Interest Income Offset	(283)	11					
12										Home Office Allocation-PHC	5,703	12					
13										Home Office Allocation-PHN	23,321	13					
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ 28,741	14					
15	<b>TOTALS (line 9+line14)</b>						\$ 1,711,060	\$ 1,619,248			\$ 148,658	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**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>			
1. Real Estate Tax accrual used on 2011 report.			\$	<b>53,460</b>	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2011		\$	<b>52,346</b>	2
3. Under or (over) accrual (line 2 minus line 1).			\$	<b>(1,114)</b>	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	<b>53,916</b>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.				<b>422</b>	
<b>TOTAL REFUND</b>	\$	<b>For</b>	<b>Tax Year.</b>		
				<b>Home Office Allocation</b>	<b>422</b>
				\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	<b>53,224</b>	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2007	<b>67,288</b>			8
	2008	<b>47,759</b>			9
	2009	<b>51,692</b>			10
	2010	<b>51,882</b>			11
	2011	<b>52,346</b>			12
<b>Accrual based on prior year tax bill.</b>					
<b>FOR BHF USE ONLY</b>					
	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

**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.**

## 2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Nokomis Rehab & Health Care Center COUNTY Montgomery

FACILITY IDPH LICENSE NUMBER 0050641

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 2011 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 2011.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>08-23-276-016</u>	<u>Long-Term Care Facility</u>	\$ <u>52,345.86</u>	\$ <u>52,345.86</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>52,345.86</u></u>	\$ <u><u>52,345.86</u></u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?                 YES        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: 32,807 B. General Construction Type: Exterior Brick Frame Steel & Brick 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>217,800</u>	<u>2007</u>	<u>\$ 60,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>217,800</b>		<b>\$ 60,000</b>	<b>3</b>

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	92	2007	1970	1,200,000		25	48,000	\$ 48,000	\$ 264,000
5									
6									
7									
8									
<b>Improvement Type**</b>									
9	Water Heater		2008	10,490		10	1,050	1,050	4,725
10	Smoke Detector		2009	2,799		7	400	400	1,400
11	Carpet		2010	2,652		15	177	177	531
12	Roof Repair		2010	9,362		7	1,337	1,337	3,343
13	Roof Repair-Front Entry Area		2011	5,753		25	230	230	345
14	Roof Repair		2012	2,875		7	205	205	205
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31	Building Booked				48,000			(48,000)	
32	Building Improvement Booked				3,467			(3,467)	
33									
34	2012-Home Office Allocation-Land Improvements			716			46	46	
35	2012-Home Office Allocation-Building Improvements			7,670			184	184	
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 Nokomis Rehab & Health Care Center

# 0050641

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	<b>TOTAL (lines 4 thru 69)</b>		\$ 1,242,317	\$ 51,467		\$ 51,629	\$ 162	\$ 274,549	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	\$ 164,607	\$ 23,437	\$ 16,461	\$ (6,976)	5-10 yrs.	\$ 83,184	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Home Office Allocation			2,770	2,770			74
75	TOTALS	\$ 164,607	\$ 23,437	\$ 19,231	\$ (4,206)		\$ 83,184	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)	\$ 1,466,924	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 74,904	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 70,860	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (4,044)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 357,733	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 Nokomis Rehab & Health Care Center

# 0050641

Report Period Beginning: 1/1/2012

Ending: 12/31/2012

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.  YES  NO

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

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending	Annual Rent
--------------------	-------------

12. \_\_\_\_\_ /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: \$ 11,151 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	<u>N/A</u>		\$	\$	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	21

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

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

**Nokomis Rehab & Health Care Center**

**0049114**

**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	\$	6,152
Dishwasher		1,537
Laundry Equipment		-
Copier		2,945
Home Office Allocation		517
		<u>11,151</u>

Facility Name & ID Number Nokomis Rehab & Health Care Center # 0050641 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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
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)	
<b>TOTAL TRAINED</b>	

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

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

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

	Service	1 Schedule V Line & Column Reference	2 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	3 Cost	Units	5 Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	3,123	\$ 46,848	\$	3,123	\$ 46,848	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,347	20,212		1,347	20,212	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		5,357	80,350		5,357	80,350	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				47,068		47,068	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	<b>TOTAL</b>			\$	9,827	\$ 147,410	\$ 47,068	9,827	\$ 194,478	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 **Nokomis Rehab & Health Care Center**# **0050641**Report 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 financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 506,196	\$ 506,196	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>83,850</u> )	403,726	403,726	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	29,207	29,207	6
7	Other Prepaid Expenses	7,357	7,357	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 946,486	\$ 946,486	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	60,000	60,000	13
14	Buildings, at Historical Cost	1,200,000	1,207,670	14
15	Leasehold Improvements, at Historical Cost	33,931	34,647	15
16	Equipment, at Historical Cost	164,607	164,607	16
17	Accumulated Depreciation (book methods)	(387,710)	(357,733)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,070,828	\$ 1,109,191	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,017,314	\$ 2,055,677	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 472,811	\$ 472,811	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	36,168	36,168	30
31	Accrued Taxes Payable (excluding real estate taxes)	18,463	18,463	31
32	Accrued Real Estate Taxes(Sch.IX-B)	53,916	53,916	32
33	Accrued Interest Payable	10,067	10,067	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Payroll Withholdings</u>	33,704	33,704	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 625,129	\$ 625,129	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,619,248	1,619,248	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 1,619,248	\$ 1,619,248	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,244,377	\$ 2,244,377	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (227,063)	\$ (188,700)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,017,314	\$ 2,055,677	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 37,314	1
2	Restatements (describe):		2
3	Rounding	(4)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 37,310	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(264,373)	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)	\$ (264,373)	17
<b>B. Transfers (Itemize):</b>			
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)	\$ (227,063)	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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,097,284	1
2	Discounts and Allowances for all Levels	(165,988)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 1,931,296</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	226,227	6
7	Oxygen	7,361	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 233,588</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	4,149	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	86,606	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	4,595	20
21	Other Medical Services	2,847	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 98,197</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	283	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 283</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Miscellaneous Revenue	2,008	28
28a	Transportation Revenue	10,044	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 12,052</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 2,275,416</b>	<b>30</b>

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	502,282	31
32	Health Care	1,000,077	32
33	General Administration	473,613	33
<b>B. Capital Expense</b>			
34	Ownership	258,260	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	97,988	35
36	Provider Participation Fee	207,569	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 2,539,789</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(264,373)</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (264,373)</b>	<b>43</b>

<b>III. Net Inpatient Revenue detailed by Payer Source</b>			
44	Medicaid - Net Inpatient Revenue	\$ 1,059,877	44
45	Private Pay - Net Inpatient Revenue	592,507	45
46	Medicare - Net Inpatient Revenue	286,298	46
47	Other-(specify) <u>Charity Therapy Allowance</u>	(6,493)	47
48	Other-(specify) <u>Insurance Contractual Allowance Revenue</u>	(893)	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	<b>\$ 1,931,296</b>	<b>49</b>

\* 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 Nokomis Rehab & Health Care Center

# 0050641

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	2,000	2,000	\$ 53,346	\$ 26.67	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,909	2,968	69,804	23.52	3
4	Licensed Practical Nurses	13,205	13,637	242,448	17.78	4
5	CNAs & Orderlies	36,107	37,222	366,820	9.85	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,497	1,554	15,549	10.01	9
10	Activity Assistants	195	196	1,881	9.60	10
11	Social Service Workers	1,994	2,083	30,560	14.67	11
12	Dietician					12
13	Food Service Supervisor	2,045	2,045	33,375	16.32	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,118	9,391	79,660	8.48	15
16	Dishwashers					16
17	Maintenance Workers	1,973	1,997	27,256	13.65	17
18	Housekeepers	8,011	8,452	76,811	9.09	18
19	Laundry	4,635	4,866	43,686	8.98	19
20	Administrator	2,080	2,080	64,536	31.03	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,795	1,860	24,779	13.32	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Transportation</u>	30	30	287	9.57	33
34	TOTAL (lines 1 - 33)	87,594	90,381	\$ 1,130,798 *	\$ 12.51	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant			35	
36	Medical Director	Monthly	11,000	L9, C3	36
37	Medical Records Consultant	7	175	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,211	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)	7	\$ 14,386		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

Template

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

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	-	-		#DIV/0!
Restorative Aide				#DIV/0!
Certified Medical Technician				#DIV/0!
Alzheimer's Coordinator				#DIV/0!
Restorative Nurse				#DIV/0!
Transportation	-	-	-	#DIV/0!
Marketing				#DIV/0!
<b>TOTAL</b>				



**Nokomis Rehab & Health Care Center**

**0049114**

**Period Beginning 1/1/2012**

**Period End 12/31/2012**

**Schedule 21A**

**XIX. SUPPORT SCHEDULE**

**C. Professional Services**

<b>Vendor/Payee</b>	<b>Type</b>	<b>Amount</b>
Total (agree to Schedule V, line 19, column 3)		3,269

**Home Office Allocation**

Sorling Northrup	Legal	51
Ginoli & Company	Accountants	1,795
Miscellaneous	Computer Services	119
Nebo Systems	Computer Services	1
Advanced Answers on Demand	Computer Services	2492
Access 2 Go	Computer Services	105
Stratus Networks	Computer Services	103
Kemper Technology	Computer Services	170
CCH	Computer Services	9
Medifax	Computer Services	20
Vision Share/Ability Network	Computer Services	190
Barracuda	Computer Services	7
CIAN	Computer Services	52
Comcast	Computer Services	16
Postini	Computer Services	161
Optimizer Systems	Other Prof Fees	25
Marotta Gund Budd & Dzera	Other Prof Fees	11539
David Budde	Other Prof Fees	10
Courtney Bourban	Other Prof Fees	142
All Scripts	Other Prof Fees	435
Heritage Enterprises	Other Prof Fees	10
Miscellaneous Vendors	Other Prof Fees	3
Duane Morris	Legal	143
Peoria County Recorder	Legal	3
E-Health Data Solutions	Computer Services	38

Ability Network	Computer Services	327
Market Feasibility Advisors	Other Prof Fees	955
Total (agree to Schedule V, line 19, column 8)		<u>22,190</u>

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

Schedule 21B

XIX. SUPPORT SCHEDULE

Legal Fees

Facility

Vendor/Payee	Invoice Total	Allocation %	Total
		100%	-
<b>Home Office Allocation</b>			
Heyl, Royster, Voelker, and Allen			-
GoffWilson			-
Jackson Lewis			-
Peter Gartelos			-
Miscellaneous Vendors			-
<b>Total Legal Fees</b>			<u>-</u>

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

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

Facility Name &amp; ID Number Nokomis Rehab &amp; Health Care Center

# 0050641

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. \$ 9,281 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. \$ 207,569  
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. \$ 4,149
- (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. \$ 10,044  
c. What percent of all travel expense relates to transportation of nurses and patients? N/A  
d. Have vehicle usage logs been maintained? Adequate records have been maintained.  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Ginoli & Company
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? No  
Attach invoices and a summary of services for all architect and appraisal fees.