



Facility Name & ID Number Piper City Rehabilitation & Living Center

# 0050773 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	60	Skilled (SNF)	60	21,900	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	60	TOTALS	60	21,900	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	9,277	4,431	1,621	15,329	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,277	4,431	1,621	15,329	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.00%

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)

Meals on Wheels, Independent Living

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES  NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES  NO

I. On what date did you start providing long term care at this location?  
Date started 1/1/2010

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 1/1/2010 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 60 and days of care provided 1,613

Medicare Intermediary Wisconsin Physicians Service

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

Piper City Rehabilitation &amp; Living Center

# 0050773

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	158,142	12,252	1,023	171,417		171,417	(27,824)	143,593		1
2	Food Purchase		109,852		109,852		109,852	(24,174)	85,678		2
3	Housekeeping	103,463	22,835		126,298		126,298	(22,535)	103,763		3
4	Laundry	19,317	6,277		25,594		25,594	(4,567)	21,027		4
5	Heat and Other Utilities			54,663	54,663		54,663	(9,543)	45,120		5
6	Maintenance	61,247	8,563	26,122	95,932		95,932	(15,585)	80,347		6
7	Other (specify):* Home Off. Ben. All.							372	372		7
8	<b>TOTAL General Services</b>	342,169	159,779	81,808	583,756		583,756	(103,856)	479,900		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			7,200	7,200		7,200		7,200		9
10	Nursing and Medical Records	902,319	83,253	1,131	986,703		986,703	(331)	986,372		10
10a	Therapy			310,103	310,103		310,103		310,103		10a
11	Activities	33,890	719	366	34,975		34,975	(7,782)	27,193		11
12	Social Services	29,503			29,503		29,503		29,503		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>	965,712	83,972	318,800	1,368,484		1,368,484	(8,113)	1,360,371		16
	<b>C. General Administration</b>										
17	Administrative			116,200	116,200		116,200	(60,200)	56,000		17
18	Directors Fees										18
19	Professional Services			3,823	3,823		3,823	18,499	22,322		19
20	Dues, Fees, Subscriptions & Promotions			9,301	9,301		9,301	215	9,516		20
21	Clerical & General Office Expenses	35,653	7,909	11,524	55,086		55,086	33,446	88,532		21
22	Employee Benefits & Payroll Taxes			179,064	179,064		179,064		179,064		22
23	Inservice Training & Education							53	53		23
24	Travel and Seminar							5	5		24
25	Other Admin. Staff Transportation			11,654	11,654		11,654	3,619	15,273		25
26	Insurance-Prop.Liab.Malpractice			23,213	23,213		23,213	597	23,810		26
27	Other (specify):* Home Off. Ben. All.							7,452	7,452		27
28	<b>TOTAL General Administration</b>	35,653	7,909	354,779	398,341		398,341	3,686	402,027		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,343,534	251,660	755,387	2,350,581		2,350,581	(108,283)	2,242,298		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			43,030	43,030		43,030	(6,512)	36,518			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			68,532	68,532		68,532	4,225	72,757			32
33	Real Estate Taxes			35,774	35,774		35,774	395	36,169			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			30,760	30,760		30,760	393	31,153			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			178,096	178,096		178,096	(1,499)	176,597			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		62,741		62,741		62,741		62,741			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			177,467	177,467		177,467		177,467			42
43	Other (specify):* <b>Non-allowable Costs</b>		1,844	36,868	38,712		38,712	(38,712)				43
44	<b>TOTAL Special Cost Centers</b>		64,585	214,335	278,920		278,920	(38,712)	240,208			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,343,534	316,245	1,147,818	2,807,597		2,807,597	(148,494)	2,659,103			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 Piper City Rehabilitation & Living Center

# 0050773

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	(1,896)	2		4
5	Telephone, TV & Radio in Resident Rooms	(7,192)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(1,593)	30		9
10	Interest and Other Investment Income	(1,106)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(110)	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	(8,266)	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	(12,012)	43		24
25	Fund Raising, Advertising and Promotional	(2,897)	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	(131,205)	various		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (166,277)		\$	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)	17,783	Various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 17,783		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (148,494)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

## Piper City Rehabilitation &amp; Living Center

ID# 0050773

Report Period Beginning: 1/1/2012

Ending: 12/31/2012

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (1,706)	43	1
2	X-Rays-Part A	(1,732)	43	2
3	Offset Miscellaneous Nursing Supplies Revenue	(358)	10	3
4	Offset Transportation Revenue	(7,782)	11	4
5	Offset Miscellaneous Office Supplies Revenue	(219)	21	5
6	Resident Flowers	(441)	43	6
7	Disallowed Special Events	(256)	43	7
8	Independent Living Dietary Cost Offset	(30,615)	1	8
9	Independent Living Food Cost Offset	(19,620)	2	9
10	Independent Living Housekeeping Cost Offset	(22,557)	3	10
11	Independent Living Laundry Cost Offset	(4,571)	4	11
12	Independent Living Utilities Cost Offset	(9,763)	5	12
13	Independent Living Maintenance Cost Offset	(17,133)	6	13
14	Independent Living Depreciation Cost Offset	(7,600)	30	14
15	Meals on Wheels Offset	(2,752)	2	15
16	IDES Interest Offset	(4,100)	43	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	<b>Total</b>		(131,205)	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Piper City Rehabilitation & Living Center# 0050773

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	(30,615)	2,791	0	0	0	0	0	0	0	0	0	(27,824)	1
2	Food Purchase	(24,268)	94	0	0	0	0	0	0	0	0	0	(24,174)	2
3	Housekeeping	(22,557)	22	0	0	0	0	0	0	0	0	0	(22,535)	3
4	Laundry	(4,571)	4	0	0	0	0	0	0	0	0	0	(4,567)	4
5	Heat and Other Utilities	(9,763)	220	0	0	0	0	0	0	0	0	0	(9,543)	5
6	Maintenance	(17,133)	1,548	0	0	0	0	0	0	0	0	0	(15,585)	6
7	Other (specify):*	0	372	0	0	0	0	0	0	0	0	0	372	7
8	<b>TOTAL General Services</b>	<b>(108,907)</b>	<b>5,051</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>(103,856)</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	(358)	27	0	0	0	0	0	0	0	0	0	(331)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(7,782)	0	0	0	0	0	0	0	0	0	0	(7,782)	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>(8,140)</b>	<b>27</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>(8,113)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(60,200)	0	0	0	0	0	0	0	0	0	(60,200)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	15,074	0	0	0	0	0	0	0	0	0	15,074	19
20	Fees, Subscriptions & Promotions	0	0	215	3,425	0	0	0	0	0	0	0	3,640	20
21	Clerical & General Office Expenses	(219)	0	31,588	0	0	0	0	0	0	0	0	31,369	21
22	Employee Benefits & Payroll Taxes	0	0	0	2,077	0	0	0	0	0	0	0	2,077	22
23	Inservice Training & Education	0	0	53	0	0	0	0	0	0	0	0	53	23
24	Travel and Seminar	0	0	5	0	0	0	0	0	0	0	0	5	24
25	Other Admin. Staff Transportation	0	0	3,619	0	0	0	0	0	0	0	0	3,619	25
26	Insurance-Prop.Liab.Malpractice	0	0	597	0	0	0	0	0	0	0	0	597	26
27	Other (specify):*	0	0	7,452	0	0	0	0	0	0	0	0	7,452	27
28	<b>TOTAL General Administration</b>	<b>(219)</b>	<b>(45,126)</b>	<b>43,529</b>	<b>5,502</b>	<b>0</b>	<b>3,686</b>	<b>28</b>						
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(117,266)</b>	<b>(40,048)</b>	<b>43,529</b>	<b>5,502</b>	<b>0</b>	<b>(108,283)</b>	<b>29</b>						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Piper City Rehabilitation & Living Center

# 0050773

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	(9,193)	0	2,681	0	0	0	0	0	0	0	0	(6,512)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,106)	0	5,331	0	0	0	0	0	0	0	0	4,225	32
33	Real Estate Taxes	0	0	395	0	0	0	0	0	0	0	0	395	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	393	0	0	0	0	0	0	0	0	393	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(10,299)</b>	<b>0</b>	<b>8,800</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>(1,499)</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):*	(38,712)	0	0	0	0	0	0	0	0	0	0	(38,712)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(38,712)</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>(38,712)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(166,277)</b>	<b>(40,048)</b>	<b>52,329</b>	<b>5,502</b>	<b>0</b>	<b>(148,494)</b>	<b>45</b>						

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%	\$ 2,791	\$ 2,791	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	94	94	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	22	22	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	4	4	4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	220	220	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	1,548	1,548	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	372	372	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	27	27	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	116,200	Petersen Health Care, Inc.	100.00%	56,000	(60,200)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	15,074	15,074	12
13	V							13
14	Total		\$ 116,200			\$ 76,152	\$ * (40,048)	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%	\$ 215	\$	215	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	31,588		31,588	16
17	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	53		53	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	5		5	18
19	V	25 Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	3,619		3,619	19
20	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	597		597	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	7,452		7,452	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	2,681		2,681	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	5,331		5,331	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	395		395	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%	393		393	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		\$			\$ 52,329	\$ *	52,329	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	\$	Midwest Health Operations, LLC	100.00%	\$ 0	\$	15	
16	V	2 Food		Midwest Health Operations, LLC	100.00%	0		16	
17	V	3 Housekeeping		Midwest Health Operations, LLC	100.00%	0		17	
18	V	4 Laundry		Midwest Health Operations, LLC	100.00%	0		18	
19	V	5 Utilities		Midwest Health Operations, LLC	100.00%	0		19	
20	V	6 Maintenance		Midwest Health Operations, LLC	100.00%	0		20	
21	V	7 Mgmt. Allocation of Benefits		Midwest Health Operations, LLC	100.00%	0		21	
22	V	10 Nursing and Medical Records		Midwest Health Operations, LLC	100.00%	0		22	
23	V	12 Social Services		Midwest Health Operations, LLC	100.00%	0		23	
24	V	17 Administrative		Midwest Health Operations, LLC	100.00%	0		24	
25	V	19 Professional Services		Midwest Health Operations, LLC	100.00%	0		25	
26	V	20 Dues, Fees, Subs & Promotions		Midwest Health Operations, LLC	100.00%	3,425	3,425	26	
27	V	21 Clerical and General Office		Midwest Health Operations, LLC	100.00%	0		27	
28	V	22 Employee Benefits & Payroll		Midwest Health Operations, LLC	100.00%	2,077	2,077	28	
29	V	23 Inservice Training & Education		Midwest Health Operations, LLC	100.00%	0		29	
30	V	24 Travel and Seminar		Midwest Health Operations, LLC	100.00%	0		30	
31	V	25 Other Admin. Staff Transport.		Midwest Health Operations, LLC	100.00%	0		31	
32	V	26 Insurance-Prop./Liab./Malprac.		Midwest Health Operations, LLC	100.00%	0		32	
33	V	27 Mgmt. Allocation of Benefits		Midwest Health Operations, LLC	100.00%	0		33	
34	V	30 Depreciation		Midwest Health Operations, LLC	100.00%	0		34	
35	V	32 Interest		Midwest Health Operations, LLC	100.00%	0		35	
36	V	33 Real Estate Taxes		Midwest Health Operations, LLC	100.00%	0		36	
37	V	34 Rent-Facility and Grounds		Midwest Health Operations, LLC	100.00%	0		37	
38	V	35 Rent-Equipment & Vehicles		Midwest Health Operations, LLC	100.00%	0		38	
39	Total		\$			\$ 5,502	\$ *	5,502	39

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

Facility Name &amp; ID Number

Piper City Rehabilitation &amp; Living Center

# 0050773

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

Piper City Rehabilitation &amp; Living Center

# 0050773

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

Piper City Rehabilitation &amp; Living Center

# 0050773

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 Piper City Rehabilitation & Living Center

# 0050773

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 Piper City Rehabilitation & Living Center # 0050773 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 Piper City Rehabilitation & Living Center

# 0050773

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	15,329	\$ 2,791	1
2	2	Food	Resident Days	1,569,393	74	9,632	0	15,329	94	2
3	3	Housekeeping	Resident Days	1,569,393	74	2,201	0	15,329	22	3
4	4	Laundry	Resident Days	1,569,393	74	397	0	15,329	4	4
5	5	Utilities	Resident Days	1,569,393	74	22,546	0	15,329	220	5
6	6	Maintenance	Resident Days	1,569,393	74	158,485	73,431	15,329	1,548	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,569,393	74	38,057	0	15,329	372	7
8	10	Nursing and Medical Records	Resident Days	1,569,393	74	2,750	0	15,329	27	8
9	10A	Therapy	Resident Days	1,569,393	74	0	0	15,329	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,569,393	74	0	0	15,329	0	10
11	17	Administrative	Resident Days	1,569,393	74	4,353,655	4,353,655	15,329	56,000	11
12	19	Professional Services	Resident Days	1,569,393	74	1,543,275	0	15,329	15,074	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,569,393	74	21,988	0	15,329	215	13
14	21	Clerical and General Office	Resident Days	1,569,393	74	3,233,970	2,816,787	15,329	31,588	14
15	23	Inservice Training & Education	Resident Days	1,569,393	74	5,397	0	15,329	53	15
16	24	Travel and Seminar	Resident Days	1,569,393	74	535	0	15,329	5	16
17	25	Other Admin. Staff Transport.	Resident Days	1,569,393	74	370,568	0	15,329	3,619	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,569,393	74	61,077	0	15,329	597	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,569,393	74	762,912	0	15,329	7,452	19
20	30	Depreciation	Resident Days	1,569,393	74	274,514	0	15,329	2,681	20
21	32	Interest	Resident Days	1,569,393	74	545,764	0	15,329	5,331	21
22	33	Real Estate Taxes	Resident Days	1,569,393	74	40,424	0	15,329	395	22
23	34	Rent-Facility and Grounds	Resident Days	1,569,393	74	0	0	15,329	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,569,393	74	40,223	0	15,329	393	24
25	TOTALS					\$ 11,774,077	\$ 7,528,087		\$ 128,481	25

Facility Name & ID Number Piper City Rehabilitation & Living Center

# 0050773

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

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

Name of Related Organization Midwest 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

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	84,913	6	\$	15,329	\$	1
2	2	Food	Resident Days	84,913	6		15,329		2
3	3	Housekeeping	Resident Days	84,913	6		15,329		3
4	4	Laundry	Resident Days	84,913	6		15,329		4
5	5	Utilities	Resident Days	84,913	6		15,329		5
6	6	Maintenance	Resident Days	84,913	6		15,329		6
7	7	Mgmt. Allocation of Benefits	Resident Days	84,913	6		15,329		7
8	10	Nursing and Medical Records	Resident Days	84,913	6		15,329		8
9	10A	Therapy	Resident Days	84,913	6		15,329		9
10	15	Mgmt. Allocation of Benefits	Resident Days	84,913	6		15,329		10
11	17	Administrative	Resident Days	84,913	6		15,329		11
12	19	Professional Services	Resident Days	84,913	6	15,586	15,329	3,425	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	84,913	6		15,329		13
14	21	Clerical and General Office	Resident Days	84,913	6	9,450	15,329	2,077	14
15	22	Employee Benefits & Payroll	Resident Days	84,913	6		15,329		15
16	24	Travel and Seminar	Resident Days	84,913	6		15,329		16
17	25	Other Admin. Staff Transport.	Resident Days	84,913	6		15,329		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	84,913	6		15,329		18
19	27	Mgmt. Allocation of Benefits	Resident Days	84,913	6		15,329		19
20	30	Depreciation	Resident Days	84,913	6		15,329		20
21	32	Interest	Resident Days	84,913	6		15,329		21
22	33	Real Estate Taxes	Resident Days	84,913	6		15,329		22
23	34	Rent-Facility and Grounds	Resident Days	84,913	6		15,329		23
24	35	Rent-Equipment & Vehicles	Resident Days	84,913	6		15,329		24
25	TOTALS					\$ 25,036	\$	\$ 5,502	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	Name of Lender	2		3	4	5	6		8	9	10	11						
		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	Morton Community Bank		X	Mortgage	\$20,000.00	9/27/12	\$ 1,796,875	\$ 1,763,962	8/27/17	6.0000	\$ 30,743	1						
2												2						
3	Vermillion Valley Bank		X	Mortgage	\$6,346.90	3/31/11	\$ 750,000	\$ Paid	4/15/2026	5.6070	\$ 32,307	3						
4												4						
5												5						
<b>Working Capital</b>																		
6												6						
7												7						
8												8						
9	<b>TOTAL Facility Related</b>				\$26,346.90		\$ 2,546,875	\$ 1,763,962			\$ 63,050	9						
<b>B. Non-Facility Related*</b>																		
10											5,482	10						
11											(1,106)	11						
12											5,331	12						
13												13						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ 9,707	14						
15	<b>TOTALS (line 9+line14)</b>						\$ 2,546,875	\$ 1,763,962			\$ 72,757	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>36,480</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>35,594</b>	2	
3. Under or (over) accrual (line 2 minus line 1).			\$ <b>(886)</b>	3	
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)			\$ <b>36,660</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.			\$	6	
		<b>Home Office Allocation</b>	<b>395</b>		
<b>TOTAL REFUND</b>	<b>\$</b>	<b>For</b>	<b>Tax Year.</b>		
					<b>(Attach a copy of the real estate tax appeal board's decision.)</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$ <b>36,169</b>	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2007		8		
	2008		9		
	2009		10		
	2010	<b>35,372</b>	11		
	2011	<b>35,594</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.**



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: 20,804 B. General Construction Type: Exterior Brick/Wood 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>20,804</u>	<u>2011</u>	<u>\$ 40,500</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>20,804</b>		<b>\$ 40,500</b>	<b>3</b>

Facility Name & ID Number Piper City Rehabilitation & Living Center

# 0050773

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	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	60		2011		\$ 744,500	\$	25	\$ 29,780	\$ 29,780	\$ 44,670
5										
6										
7										
8										
	Improvement Type**									
9	Concrete Replacement		2010		7,606		15	508	508	1,270
10										
11										
12										
13										
14										
15										
16										
17										
18										
19										
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30	Land Improvements Booked					507			(507)	
31	Building Booked					29,780			(29,780)	
32	Building Improvement Booked					7,600			(7,600)	
33										
34	2012-Home Office Allocation-Land Improvements				669			43	43	
35	2012-Home Office Allocation-Building Improvements				7,169			172	172	
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 Piper City Rehabilitation & Living Center

# 0050773

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)		\$ 759,944	\$ 37,887		\$ 30,503	\$ (7,384)	\$ 45,940	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	\$ 32,533	\$ 4,648	\$ 3,253	\$ (1,395)	10 yrs.	\$ 4,984	71
72	Current Year Purchases	5,923	495	296	(199)	10 yrs.	296	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			2,466	2,466			74
75	TOTALS	\$ 38,456	\$ 5,143	\$ 6,015	\$ 872		\$ 5,280	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)	\$ 838,900	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 43,030	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 36,518	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (6,512)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 51,220	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	Independent Living Facility-2011	\$ 190,000	\$ 7,600	\$ 13,300	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 190,000	\$ 7,600	\$ 13,300	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	<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: \$ 24,760 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	2010 Ford Van	\$ 532.77	\$ 6,393	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$ 532.77	\$ 6,393	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.

**Piper City Rehabilitation and Living Center**

**0049833**

**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	\$	21,365
Dishwasher		608
Laundry Equipment		-
Copier		2,394
Home Office Allocation		393
		<u>24,760</u>

Facility Name & ID Number Piper City Rehabilitation & Living Center # 0050773 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		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**

<b>COMPLETED</b>		
1. From this facility		
2. From other facilities (f)		
<b>DROP-OUTS</b>		
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		3	4		5	6	7	8		
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)			
			Units of Service			Units	Cost						
1	Licensed Occupational Therapist	10A(3)	hrs	\$	10,405	\$	156,072	\$	10,405	\$	156,072	1	
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,279		19,184		1,279		19,184	2	
3	Licensed Recreational Therapist		hrs									3	
4	Licensed Physical Therapist	10A(3)	hrs		8,990		134,847		8,990		134,847	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					62,741			62,741	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>			\$	20,674	\$	310,103	\$	62,741	20,674	\$	372,844	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 Piper City Rehabilitation & Living Center

# 0050773

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 fin: 932,001

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 1,203,333	\$ 1,203,333	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>38,000</u> )	536,893	536,893	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	22,669	22,669	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (Due to Due From Intercompany)	1,067,609	1,067,609	8
9	Other(specify): <u>Security Deposit</u>	8,778	8,778	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,839,282	\$ 2,839,282	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	40,500	40,500	13
14	Buildings, at Historical Cost	752,106	751,669	14
15	Leasehold Improvements, at Historical Cost		8,275	15
16	Equipment, at Historical Cost	38,456	38,456	16
17	Accumulated Depreciation (book methods)	(62,065)	(51,220)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spec <u>Loan Costs</u> )	6,118	6,118	22
23	Other(specify): <u>Building - Assist Living</u>	176,700	176,700	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 951,815	\$ 970,498	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,791,097	\$ 3,809,780	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 580,876	\$ 580,876	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	81,255	81,255	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,931	2,931	31
32	Accrued Real Estate Taxes(Sch.IX-B)	36,660	36,660	32
33	Accrued Interest Payable	1,999	1,999	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Payroll Withholdings</u>	33,514	33,514	36
37	<u>Accrued Management Fees</u>	376,582	376,582	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,113,817	\$ 1,113,817	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,763,962	1,763,962	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>	\$ 1,763,962	\$ 1,763,962	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,877,779	\$ 2,877,779	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 913,318	\$ 932,001	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,791,097	\$ 3,809,780	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 724,547	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 724,547	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	188,771	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)	\$ 188,771	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)	\$ 913,318	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	
<b>I. Revenue</b>		<b>Amount</b>	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,636,189	1
2	Discounts and Allowances for all Levels	(253,098)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 2,383,091</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	465,912	6
7	Oxygen	7,114	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 473,026</b>	8
<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	4,648	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	106,614	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	7,871	20
21	Other Medical Services	11,653	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 130,786</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	1,106	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 1,106</b>	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Miscellaneous Revenue	577	28
28a	Transportation Revenue	7,782	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 8,359</b>	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 2,996,368</b>	30

		2	
<b>II. Expenses</b>		<b>Amount</b>	
<b>A. Operating Expenses</b>			
31	General Services	583,756	31
32	Health Care	1,368,484	32
33	General Administration	398,341	33
<b>B. Capital Expense</b>			
34	Ownership	178,096	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	101,453	35
36	Provider Participation Fee	177,467	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>\$ 2,807,597</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>188,771</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 188,771</b>	43

<b>III. Net Inpatient Revenue detailed by Payer Source</b>			
44	Medicaid - Net Inpatient Revenue	\$ 1,315,769	44
45	Private Pay - Net Inpatient Revenue	608,773	45
46	Medicare - Net Inpatient Revenue	325,390	46
47	Other-(specify) <u>Independent Living Revenue</u>	144,297	47
48	Other-(specify) <u>Charity and Insurance Allowances</u>	(11,138)	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	<b>\$ 2,383,091</b>	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 Piper City Rehabilitation & Living Center

# 0050773

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	2,051	2,051	\$ 62,757	\$ 30.60	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,414	2,430	61,040	25.12	3
4	Licensed Practical Nurses	12,089	12,515	291,851	23.32	4
5	CNAs & Orderlies	31,766	33,150	401,103	12.10	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,959	2,061	20,317	9.86	9
10	Activity Assistants	475	475	4,033	8.49	10
11	Social Service Workers	1,788	1,950	29,503	15.13	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	27,234	13.09	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,420	13,143	130,908	9.96	15
16	Dishwashers					16
17	Maintenance Workers	4,188	4,300	61,247	14.24	17
18	Housekeepers	10,242	10,747	103,463	9.63	18
19	Laundry	2,033	2,175	19,317	8.88	19
20	Administrator	2,080	2,080	56,000	26.92	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,998	2,143	35,653	16.64	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	1,733	1,880	26,069	13.87	31
32	Other Health C: Care Plan Coord	2,336	2,435	59,499	24.43	32
33	Other(specify) <u>Transportation</u>	729	729	9,540	13.09	33
34	TOTAL (lines 1 - 33)	92,381	96,344	\$ 1,399,534 *	\$ 14.53	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	20	\$ 1,023	L1, C3	35
36	Medical Director	Monthly	7,200	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,023	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)	20	\$ 11,246		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>				

**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	
Sharon Bargmann	Administrator	0	\$ 56,000	Workers' Compensation Insurance	\$ 27,733	IDPH License Fee	\$ 3,980	
				Unemployment Compensation Insurance	31,767	Advertising: Employee Recruitment	65	
				FICA Taxes	105,802	Health Care Worker Background Check		
				Employee Health Insurance	13,201	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks	36	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	1,888	
				Employee Relations	300	Home Office Allocation	215	
				Employee Retirement	261	Sewer License	3,000	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 56,000					
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			\$ 116,200	N/A			Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	
							Home Office Allocation	5
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 116,200	TOTAL			Entertainment Expense	( )
(Attach a copy of any management service agreement)							(agree to Sch. V, line 24, col. 8)	
C. Professional Services							TOTAL	
Vendor/Payee	Type		Amount				\$ 5	
Frontier	Computer Services		\$ 1,304					
E-Health Data Solutions	Computer Services		935					
Allscripts	Computer Services		1,200					
Honkamp Krueger & Co.	Computer Services		384					
TOTAL (agree to Schedule V, line 19, column 3)								
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 3,823					

\* Attach copy of IMRF notifications

\*\*See instructions.

**Piper City Rehabilitation and Living Center**

**0049833**

**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)		3,823

**Home Office Allocation**

Sorling Northrup	Legal	48
Ginoli & Company	Accountants	2,488
Miscellaneous	Computer Services	140
Nebo Systems	Computer Services	1
Advanced Answers on Demand	Computer Services	2329
Access 2 Go	Computer Services	98
Stratus Networks	Computer Services	96
Kemper Technology	Computer Services	159
CCH	Computer Services	8
Medifax	Computer Services	19
Vision Share/Ability Network	Computer Services	178
Barracuda	Computer Services	6
CIAN	Computer Services	48
Comcast	Computer Services	15
Postini	Computer Services	151
Optimizer Systems	Other Prof Fees	24
Marotta Gund Budd & Dzera	Other Prof Fees	10786
David Budde	Other Prof Fees	9
Courtney Bourban	Other Prof Fees	133
All Scripts	Other Prof Fees	407
Heritage Enterprises	Other Prof Fees	9
Miscellaneous Vendors	Other Prof Fees	3
Peoria County Recorder	Legal	9
E-Health Data Solutions	Computer Services	1,335

Total (agree to Schedule V, line 19, column 8)

22,322

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>-</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 Piper City Rehabilitation &amp; Living Center

# 0050773

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. \$ 22,609 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. \$ 177,467  
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. \$ 1,896
- (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. \$ 7,782  
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. \$ \_\_\_\_\_**
- (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.

Piper City Rehabilitation and Living Center  
 0049833  
 Period Beginning 1/1/2012  
 Period End 12/31/2012

**Independent Living Offset**

**Schedule 23A**

**Census Days Summary:**

	Days	%
Independent Living	3,332	17.86%
Nursing Home	15,329	82.14%
	<u>18,661</u>	<u>100.00%</u>

<b>Expense Offset:</b>	<b>Total Amount</b>	<b>Ind. Liv %</b>	<b>Ind. Liv Offset</b>	<b>Basis For Allocation</b>	<b>Line</b>
Dietary	171,417	17.86%	30,615	Census	1
Food	109,852	17.86%	19,620	Census	2
Housekeeping	126,298	17.86%	22,557	Census	3
Laundry	25,594	17.86%	4,571	Census	4
Utilities	54,663	17.86%	9,763	Census	5
Maintenance	95,932	17.86%	17,133	Census	6
Depreciation (Building)	<u>7,600</u>	100.00%	<u>7,600</u>	Beds	30
<b>Total</b>	<u><u>591,356</u></u>		<u><u>111,859</u></u>		

Note: Computed overhead cost of Independent Living based on census days. Independent Living depreciation expense was calculated based on total number of beds.

Independent Living overhead and depreciation costs have been offset on P5A.

RECONCILIATION REPORT

Template

07:05 PM 6/13/2013

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-148,494	equal to	-148,494	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	72,757	equal to	72,757	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	36,169	equal to	36,169	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	0	equal to	0	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	36,518	equal to	36,518	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	31,153	equal to	31,153	0	O.K.	Pg14 J30+N40	B. + C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	310,103	equal to	310,103	0	O.K.	Pg16 Z12+Z14..	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv.- Supplies	62,741	equal to	62,741	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	583,756	equal to	583,756	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	1,368,484	equal to	1,368,484	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	398,341	equal to	398,341	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	178,096	equal to	178,096	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	101,453	equal to	101,453	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+t	N/A	38to41+43	4
Income Stat. Prov. Partic.	177,467	equal to	177,467	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	902,319	equal to	902,319	0	O.K.	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	33,890	equal to	33,890	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	29,503	equal to	29,503	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	158,142	equal to	158,142	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	61,247	equal to	61,247	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	103,463	equal to	103,463	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	19,317	equal to	19,317	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	56,000	equal to		0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	35,653	equal to	35,653	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	1,399,534	equal to	1,343,534	56,000	FAILED	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	1,023	< or = to	1,023	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	7,200	< or = to	7,200	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	3,023	< or = to	1,131	1,892	FAILED	Pg20 X14..X16+	B. & C.	i7to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to	366	-366	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	0	< or = to		0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	56,000	equal to		0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	116,200	equal to	116,200	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3

Supp. Sched.- Prof. Serv.	3,823	equal to	3,823	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	179,064	equal to	179,064	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	9,516	equal to	9,516	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	5	equal to	5	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	177,467	equal to	177,467	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	0	< or = to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	1,613	equal to	1,621	-8	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	17,783	equal to	17,783	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4I	B.	14	8
Total loan balance	1,763,962	equal to	1,763,962	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	36,660	equal to	36,660	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	40,500	equal to	40,500	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	759,944	equal to	759,944	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	38,456	equal to	38,456	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	51,220	equal to	51,220	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	913,318	equal to	913,318	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	188,771	equal to	188,771	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31...§	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	3,791,097	equal to	3,791,097	0	O.K.	Pg17:H41	N/A	25	1	Pg17 S41	N/A	48	1

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Adjusted Total
1. Dietary	158,142	12,252	1,023	171,417	0	171,417	-27,824	143,593
2. Food Purchase	0	109,852	0	109,852	0	109,852	-24,174	85,678
3. Housekeeping	103,463	22,835	0	126,298	0	126,298	-22,535	103,763
4. Laundry	19,317	6,277	0	25,594	0	25,594	-4,567	21,027
5. Heat and Other Utilities	0	0	54,663	54,663	0	54,663	-9,543	45,120
6. Maintenance	61,247	8,563	26,122	95,932	0	95,932	-15,585	80,347
7. Other (specify)*	0	0	0	0	0	0	372	372
8. Total General Services	342,169	159,779	81,808	583,756	0	583,756	-103,856	479,900
9. Medical Director	0	0	7,200	7,200	0	7,200	0	7,200
10. Nursing & Medical Records	902,319	83,253	1,131	986,703	0	986,703	-331	986,372
10a. Therapy	0	0	310,103	310,103	0	310,103	0	310,103
11. Activities	33,890	719	366	34,975	0	34,975	-7,782	27,193
12. Social Services	29,503	0	0	29,503	0	29,503	0	29,503
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	965,712	83,972	318,800	1,368,484	0	1,368,484	-8,113	1,360,371
17. Administrative	0	0	116,200	116,200	0	116,200	-60,200	56,000
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	3,823	3,823	0	3,823	18,499	22,322
20. Fees, Subscriptions & Promotion	0	0	9,301	9,301	0	9,301	215	9,516
21. Clerical & General Office	35,653	7,909	11,524	55,086	0	55,086	33,446	88,532
22. Employee Benefits & Payroll	0	0	179,064	179,064	0	179,064	0	179,064
23. Inservice Training & Education	0	0	0	0	0	0	53	53
24. Travel and Seminar	0	0	0	0	0	0	5	5
25. Other Admin. Staff Trans	0	0	11,654	11,654	0	11,654	3,619	15,273
26. Insurance-Prop.Liab.Malpractice	0	0	23,213	23,213	0	23,213	597	23,810
27. Other (specify)*	0	0	0	0	0	0	7,452	7,452
28. Total General Adminis	35,653	7,909	354,779	398,341	0	398,341	3,686	402,027
29. Total General Administrative	1,343,534	251,660	755,387	2,350,581	0	2,350,581	-108,283	2,242,298
30. Depreciation	0	0	43,030	43,030	0	43,030	-6,512	36,518
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	68,532	68,532	0	68,532	4,225	72,757
33. Real Estate	0	0	35,774	35,774	0	35,774	395	36,169

34. Rent - Facility & Grounds	0	0	0	0	0	0	0	0
35. Rent - Equipment & Vehicles	0	0	30,760	30,760	0	30,760	393	31,153
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	178,096	178,096	0	178,096	-1,499	176,597
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	62,741	0	62,741	0	62,741	0	62,741
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	177,467	177,467	0	177,467	0	177,467
43. Other (specify):*	0	1,844	36,868	38,712	0	38,712	-38,712	0
44. Total Special Cost Ce	0	64,585	214,335	278,920	0	278,920	-38,712	240,208
45. Grand Total	1,343,534	316,245	1,147,818	2,807,597	0	2,807,597	-148,494	2,659,103

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	1,203,333	1,203,333
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Receivable	536,893	536,893
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	22,669	22,669
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	25,000	25,000
9. Other (specify):	8,778	8,778
10. Total current assets	1,796,673	1,796,673
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	40,500	40,500
14. Buildings, at Historical Cost	752,106	751,669
15. Leasehold Improvements, Historical Cost	0	8,275
16. Equipment, at Historical Cost	38,456	38,456
17. Accumulated Depreciation (book methods)	-62,065	-51,220
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	6,118	6,118
23. other (specify):	176,700	176,700
24. Total Long-Term Assets	951,815	970,498
25. Total Assets	2,748,488	2,767,171
CURRENT LIABILITIES		
26. Accounts Payable	580,876	580,876
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	81,255	81,255
31. Accrued Taxes Payable	2,931	2,931
32. Accrued Real Estate Taxes	36,660	36,660
33. Accrued Interest Payable	1,999	1,999
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	33,514	33,514

37. Other Current Liabilities (specify):	376,582	376,582
38. Total Current Liabilities	1,113,817	1,113,817
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	1,763,962	1,763,962
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	-1,042,609	-1,042,609
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	721,353	721,353
46.Total Liabilities	1,835,170	1,835,170
47.Total Equity	913,318	932,001
48.Total Liabilities and Equity	2,748,488	2,767,171

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	2,636,189
2. Discounts and Allowances for all Levels	-253,098
Subtotal - Inpatient Care	2,383,091
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	465,912
7. Oxygen	7,114
Subtotal - Anciliary Revenue	473,026
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	4,648
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	106,614
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiology and X-Ray	7,871
21. Other Medical Services	11,653
22. Laundry	0
Subtotal - Other Operating Revenue	130,786
24. Contributions	0
25. Interest and Other Investments Income	1,106
Subtotal - Non-Operating Revenue	1,106
27. Other Revenue (specify):	0
28. Other Revenue (specify):	8,359
Subtotal - Other Revenue	8,359
30. Total Revenue	2,996,368
31. General Services	586,311
32. Health Care	1,370,642
33. General Administration	300,284
34. Ownership	143,865

35. Special Cost Centers	75,415
35. Provider Participation Fee	32,850
37. Other	0
40. Total Expenses	2,509,367
41. Income Before Income Taxes	487,001
42. Income Taxes	0
43. Net Income or Loss for the Year	487,001

Enter Cost Center Expenses

**YOU HAVE CHOSEN THE SUPPORT CALC. THAT IS LINKED TO THE COST REPORT!!!!**

6/13/2013 07:05:22 PM

HSA Number: 4 Name: Piper City Rehabilitation & Living Center

Cost report period From: 1/1/2012 To: 12/31/2012 Base Number: 444

If this is an ICF/DD 16 facility, enter a 1 in cell C6

Licensed bed days: 21,900 Occupancy: N 15,329 Pct. of occupancy: 70.00%

Illinois Public Aid Support Rate: \$                     

Genl Services Salary/Wage: 342,169 Col 1, Line 8 ---Audit Adj:                     

Genl Admin Salary/Wage: 35,653 Col 1, Line 28 ---Audit Adj:                     

Total Salary Wage: 1,343,534 Col 1, Line 44 ---Audit Adj:                     

Employee Benefits: 179,064 Col 8, Line 22 ---Audit Adj:                     

Total General Services: 479,900 Col 8, Line 8 ---Audit Adj:                     

Total General Admin: 402,027 Col 8, Line 28 ---Audit Adj:                     

Instructions and Calculation Steps

STEP I Adjust Support Service Costs to Include Correct Amounts of Fringe Benefits and Payroll Taxes.

Fringe benefits and payroll taxes are reported as a lump sum under General Administration expenses on your cost report (Page 3, Column 10, Line 22). You will need to take this amount out of General Administration expenses and calculate the correct portions of this lump sum to be added to your general services and General Administration expenses. This is done by proration.

A. General Services

1 Determine the proportion of general services wages to total wages.

2 Multiply the total lump sum fringe amount by this proportion to get the fringe amount for General Services.

3 Add the proportioned fringe amount to your total general services expenses to get your new total general services cost.

General Services Wages (Column 1, Line 8)  
Divided by Total Wages (Column 1, Line 44)  
General service wages as percent of total wages  
Employee Benefits (Column 10, Line 22)

Allocation of Employee Benefits to General Services Costs  
Plus Total General Services (Column 10, Line 8)  
New Total General Services Cost

B.

General Administration

1 Determine the proportion of General Administration wages to total wages.

2 Multiply the total lump sum fringe amount by this proportion to get the fringes amount for General Administration.

3 Add the proportioned fringe amount to your total General Administration expenses.

4 Subtract the total lump sum fringe amount from your General Administration expenses to get your new total General Administration Cost.

General Administration Wages (Column 1, Line 28).  
Divided by Total Wages (Column 1, Line 45)  
General administration wages as a percent of total wages

Employee Benefits (Column 10, Line 22)  
Allocation of Employee Benefits to General Admin. Costs  
Plus Total General Administration (Column 10, Line 28)  
Minus Total Fringe (Column 10, Line 22)  
New Total General Administration Cost

STEP II Adjust Support Service Costs for Inflation

To calculate the impact of inflation, different inflation factors are used for the General Service and General Administration costs of your cost report. These inflation factors are listed in Table I, Inflation Multipliers. To select the appropriate inflation factors, you need to calculate your base number using the formula outlined below. Once you have calculated your base number, find it in Table I. Select the inflation factors which correspond with your base number and use these in updating your support cost.

A. Base Number Calculation

Convert the beginning and ending dates of your cost reporting period (page 1, Schedule II of your cost report) into numbers and apply the following formula:

Beginning Month + Ending Month = 13 divided by 2 =  
Beginning Day + Ending Day = 32 divided by 60.8 =  
Beginning Year + Ending Year = 224 multiplied by 6 =

Sum of the three lines  
Subtract from the sum

Base Number (expressed as a whole number, fraction dropped)

B. Select the Appropriate Inflation Multipliers

Refer to Table I, inflation Multipliers, and find the multipliers which correspond with the base number you have calculated.

General Services Multiplier:  
General Administration Multiplier:

C. Apply Inflation Multipliers to Update Cost

1 Multiply New Total General Services Cost (from Step I-A) by the appropriate multiplier from Table I:

New Total General Service Cost (Step I-A)  
General Services Multiplier (Step II-B)

Updated General Services Cost

2 Multiply New Total General Administration Cost  
(from Step I-B) by the appropriate multiplier from Table I:

New Total General Service Cost (Step I-B)  
General Administration Multiplier (Step II-B)

Updated General Services Cost

3 Total Updated Support Costs (1 + 2)

STEP III Convert Total Updated Support Costs (C-3) to Per Diem Costs  
Use one of the two procedures below to compute per diem costs.

CALCULATED PER DIEM SUPPORT COSTS

A. If the occupancy (Cost Report, Page 2, Schedule III-C) is equal to or above 93 percent, divide your total updated support costs (Step II, C, 3, above) by the total patient days (Cost Report, Page 2, Schedule III-B, Column 5, Line 14).

Total Support Costs (Step II, C, 3, above)  
Total Patient Days (Cost Report)

Support Costs per Diem

OR

B. If the occupancy is below 93 percent, calculate 93 percent of the licensed bed days (Cost Report, Page 2, Schedule III-A, Column 4, Line 7). Then subtract the total patient days (Cost Report, Page 2, Schedule III-B, Column 5, Line 14) from the result and calculate one-third of the difference. Then add the one-third difference to the total patient days to obtain your adjusted occupancy. Next divide your total updated Support Costs (Step II, C, 3 above) by your adjusted occupancy.

Licensed Bed Days  
Multiplied by

Minus total Patient Days

One-third of difference

Plus Total Patient Days

Adjusted Occupancy

Total Support Costs (Step II, C, 3, above)  
Divided by Adjusted Occupancy

Support Costs Per Diem

STEP IV Calculate Support Rate

The maximum allowable support reimbursement rate is the 75th percentile for your region. The 35th and 75th percentile rates by HSA are listed in Table II, support Rate Percentiles by HSA. Use one of the three procedures below and refer to Table II to calculate your support rate.

A. If your support costs per diem from STEP II is equal to or greater than the 75th percentile for your HSA, then your support rate is the 75th percentile rate listed in Table II.

B. If your support costs per diem from Step III is equal to or greater than the 35th percentile, but less than the 75th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate listed in Table II. Use the following procedure to calculate your rate:

75 Percentile Rate for your HSA  
Minus Support Costs Per Diem

Difference

Multiply the Difference by

One-Half of the Difference

Plus Support Costs Per Diem

Support Rate if costs are between 35th and 75th percentile

C. If your support cost per diem from Step III is below the 35th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate up to a ceiling. This ceiling is equal to 50 percent of the difference between the 35th and 75th percentiles plus \$.05. The ceiling for each HSA is listed in Table II. Use the following procedure to calculate your rate:

75 Percentile Rate for your HSA  
Minus Support Costs Per Diem

Difference

Multiply the Difference by

One-Half of the Difference

Compare one-half the difference to the  
profit ceiling for your HSA in Table II and

Enter the Lower of the Two Amounts

Plus Support Costs Per Diem

Support Rate if support costs less than 35th percentile

D. YOUR FINAL TOTAL SUPPORT RATE from A, B, or C above

75th Percentile is

35th Percentile is

Table I  
Inflation Multipliers

Base Number	General Services Multiplier	General Administration Multiplier
261	1.1187	1.1531
262	1.1182	1.1530
263	1.1178	1.1528
264	1.1071	1.1376
265	1.1067	1.1375
266	1.1062	1.1373
267	1.0975	1.1249
268	1.0971	1.1248
269	1.0966	1.1246
270	1.0887	1.1134
271	1.0882	1.1132
272	1.0877	1.1130
273	1.0815	1.1043
274	1.0811	1.1042
275	1.0806	1.1040
276	1.0730	1.0932
277	1.0725	1.0931
278	1.0720	1.0929
279	1.0666	1.0853
280	1.0661	1.0851
281	1.0657	1.0850
282	1.0588	1.0753
283	1.0583	1.0751
284	1.0579	1.0750
285	1.0535	1.0690
286	1.0531	1.0689
287	1.0527	1.0687
288	1.0413	1.0524
289	1.0409	1.0522
290	1.0404	1.0521
291	1.0321	1.0403
292	1.0317	1.0402
293	1.0313	1.0400
294	1.0254	1.0318
295	1.0250	1.0317
296	1.0246	1.0315
297	1.0228	1.0294
298	1.0224	1.0293
299	1.0219	1.0291
300	1.0166	1.0218
301	1.0162	1.0216
302	1.0158	1.0215
303	1.0076	1.0098
304	1.0072	1.0097
305	1.0067	1.0095
306	1.0000	1.0000

\$342,169  
\$1,343,534  
 25.4678%  
\$179,064  
  
 \$45,604  
\$479,900  
\$525,504

\$35,653  
\$1,343,534  
 2.6537%

Table II  
SupportRate percentiles by HSA

HSA	75th Percentile	35th Percentile	Below 35th Profit Ceiling
1	48.45	39.86	4.345
2	47.44	39.95	3.795
3	41.84	34.67	3.635
4	47.44	39.95	3.795
5	41.31	34.45	3.645
6	52.64	38.99	6.875
7	52.64	38.99	6.875
8	52.64	38.99	6.875
9	49.92	38.30	5.860
10	48.45	39.86	4.345
11	43.93	35.79	4.120

Table II (For ICF)  
SupportRate per

HSA
1
2
3
4
5
6
7
8
9
10
11

\$179,064  
\$4,752  
\$402,027  
\$179,064  
\$227,715

6.5  
0.526315789  
1344  
  
1351.026316  
907.00

444

1  
1

\$525,504  
1

\$525,504

\$227,715  
1  
\$227,715  
\$753,219

\$44.29

\$753,219  
15,329  
\$49.14

21,900  
0.93  
20,367

15,329  
5,038

1,679

15,329

17,008

\$753,219  
17008  

---

\$44.29

\$47.44  
\$44.29  
\$3.15  

---

0.5  
\$1.58  

---

\$44.29  

---

45.87

\$47.44  
\$44.29  
\$3.15

0.5

\$1.58

3.795

\$1.580

\$44.29

\$45.87

**\$45.87**

\$47.44

\$39.95

7/DD 16 Facilities)

Percentiles by HSA

Not updated with current figures

<u>75th Percentile</u>	<u>35th Percentile</u>	<u>Below 35th Profit Ceiling</u>
34.86	27.19	3.885
33.30	25.97	3.715
32.74	25.54	3.650
33.30	25.97	3.715
30.46	23.75	3.405
40.44	31.54	4.500
40.44	31.54	4.500
40.44	31.54	4.500
37.60	29.32	4.190
34.86	27.19	3.885
32.73	25.52	3.655