



Facility Name & ID Number Rosiclare Rehabilitation & Health Care Center

# 0047548 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	62	Skilled (SNF)	62	22,630	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	62	TOTALS	62	22,630	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	13,434	2,450	2,037	17,921	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,434	2,450	2,037	17,921	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.19%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES  NO

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

YES  NO

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

Date started 10/1/2005

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

YES  Date 10/1/2005 NO

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

YES  NO  If YES, enter number of beds certified 62 and days of care provided 1,921

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

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

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

**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	97,055	7,886	3,289	108,230		108,230	3,263	111,493		1
2	Food Purchase		88,185		88,185		88,185	(2,776)	85,409		2
3	Housekeeping	71,013	11,161		82,174		82,174	25	82,199		3
4	Laundry	20,123	5,580		25,703		25,703	5	25,708		4
5	Heat and Other Utilities			60,504	60,504		60,504	257	60,761		5
6	Maintenance	28,268	5,514	15,038	48,820		48,820	1,810	50,630		6
7	Other (specify):* Home Off. Ben. All.							435	435		7
8	<b>TOTAL General Services</b>	216,459	118,326	78,831	413,616		413,616	3,019	416,635		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			4,400	4,400		4,400		4,400		9
10	Nursing and Medical Records	699,438	62,901	4,139	766,478		766,478	31	766,509		10
10a	Therapy		23	327,661	327,684		327,684		327,684		10a
11	Activities	38,816	15	(31)	38,800		38,800	(13,105)	25,695		11
12	Social Services		20		20		20		20		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>	738,254	62,959	336,169	1,137,382		1,137,382	(13,074)	1,124,308		16
	<b>C. General Administration</b>										
17	Administrative			208,400	208,400		208,400	(136,715)	71,685		17
18	Directors Fees										18
19	Professional Services			1,965	1,965		1,965	76,270	78,235		19
20	Dues, Fees, Subscriptions & Promotions			5,289	5,289		5,289	290	5,579		20
21	Clerical & General Office Expenses	31,027	2,558	117,628	151,213		151,213	37,847	189,060		21
22	Employee Benefits & Payroll Taxes			136,117	136,117		136,117		136,117		22
23	Inservice Training & Education							62	62		23
24	Travel and Seminar							6	6		24
25	Other Admin. Staff Transportation			10,462	10,462		10,462	4,270	14,732		25
26	Insurance-Prop.Liab.Malpractice			19,420	19,420		19,420	697	20,117		26
27	Other (specify):* Home Off. Ben. All.							8,712	8,712		27
28	<b>TOTAL General Administration</b>	31,027	2,558	499,281	532,866		532,866	(8,561)	524,305		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	985,740	183,843	914,281	2,083,864		2,083,864	(18,616)	2,065,248		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			89,844	89,844		89,844	(8,016)	81,828			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			271,907	271,907		271,907	49,454	321,361			32
33	Real Estate Taxes			5,308	5,308		5,308	462	5,770			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			28,376	28,376		28,376	509	28,885			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			395,435	395,435		395,435	42,409	437,844			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		74,136		74,136		74,136		74,136			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			189,624	189,624		189,624		189,624			42
43	Other (specify):* <b>Non-allowable Costs</b>		54	31,552	31,606		31,606	(31,606)				43
44	<b>TOTAL Special Cost Centers</b>		74,190	221,176	295,366		295,366	(31,606)	263,760			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	985,740	258,033	1,530,892	2,774,665		2,774,665	(7,813)	2,766,852			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 Rosiclare Rehabilitation & Health Care Center

# 0047548

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	(2,886)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,932)	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	(11,229)	30		9
10	Interest and Other Investment Income	(834)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(179)	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	(9,193)	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	(3,952)	43		24
25	Fund Raising, Advertising and Promotional	(3,574)	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	(20,958)	Various		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (59,737)		\$	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)	51,924	Various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 51,924		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (7,813)		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

## Rosiclare Rehabilitation &amp; Health Care Center

ID# 0047548

Report Period Beginning: 1/1/2012

Ending: 12/31/2012

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (6,955)	43	1
2	X-Rays-Part A	(724)	43	2
3	Offset Transportation Revenue	(13,105)	11	3
4	Offset Miscellaneous Office Supplies Revenue	(77)	21	4
5	Disallowed Special Events	(4)	43	5
6	Disallowed Resident Flowers	(93)	43	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>		(20,958)	49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Rosiclare Rehabilitation &amp; Health Care Center

# 0047548

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	3,263	0	0	0	0	0	0	0	0	0	3,263	1
2	Food Purchase	(2,886)	110	0	0	0	0	0	0	0	0	0	(2,776)	2
3	Housekeeping	0	25	0	0	0	0	0	0	0	0	0	25	3
4	Laundry	0	5	0	0	0	0	0	0	0	0	0	5	4
5	Heat and Other Utilities	0	257	0	0	0	0	0	0	0	0	0	257	5
6	Maintenance	0	1,810	0	0	0	0	0	0	0	0	0	1,810	6
7	Other (specify):*	0	435	0	0	0	0	0	0	0	0	0	435	7
8	<b>TOTAL General Services</b>	<b>(2,886)</b>	<b>5,905</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>3,019</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	0	31	0	0	0	0	0	0	0	0	0	31	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(13,105)	0	0	0	0	0	0	0	0	0	0	(13,105)	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>(13,105)</b>	<b>31</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>(13,074)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(136,715)	0	0	0	0	0	0	0	0	0	(136,715)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	17,623	0	58,647	0	0	0	0	0	0	0	76,270	19
20	Fees, Subscriptions & Promotions	0	0	251	39	0	0	0	0	0	0	0	290	20
21	Clerical & General Office Expenses	(77)	0	36,929	995	0	0	0	0	0	0	0	37,847	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	62	0	0	0	0	0	0	0	0	62	23
24	Travel and Seminar	0	0	6	0	0	0	0	0	0	0	0	6	24
25	Other Admin. Staff Transportation	0	0	4,232	38	0	0	0	0	0	0	0	4,270	25
26	Insurance-Prop.Liab.Malpractice	0	0	697	0	0	0	0	0	0	0	0	697	26
27	Other (specify):*	0	0	8,712	0	0	0	0	0	0	0	0	8,712	27
28	<b>TOTAL General Administration</b>	<b>(77)</b>	<b>(119,092)</b>	<b>50,889</b>	<b>59,719</b>	<b>0</b>	<b>(8,561)</b>	<b>28</b>						
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(16,068)</b>	<b>(113,156)</b>	<b>50,889</b>	<b>59,719</b>	<b>0</b>	<b>(18,616)</b>	<b>29</b>						

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rosiclare Rehabilitation & Health Care Center# 0047548

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	(11,229)	0	3,135	78	0	0	0	0	0	0	0	(8,016)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(834)	0	6,232	44,056	0	0	0	0	0	0	0	49,454	32
33	Real Estate Taxes	0	0	462	0	0	0	0	0	0	0	0	462	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	459	50	0	0	0	0	0	0	0	509	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(12,063)</b>	<b>0</b>	<b>10,288</b>	<b>44,184</b>	<b>0</b>	<b>42,409</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):*	(31,606)	0	0	0	0	0	0	0	0	0	0	(31,606)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(31,606)</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>(31,606)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(59,737)	(113,156)	61,177	103,903	0	0	0	0	0	0	0	(7,813)	45

**VII. RELATED PARTIES**

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark B. Petersen	100	See PG6 - Supp		See PG6 - Supp		

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 3,263	\$ 3,263	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	110	110	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	25	25	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	5	5	4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	257	257	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	1,810	1,810	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	435	435	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	31	31	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	208,400	Petersen Health Care, Inc.	100.00%	71,685	(136,715)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	17,623	17,623	12
13	V							13
14	Total		\$ 208,400			\$ 95,244	\$ * (113,156)	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%	\$ 251	\$	251	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	36,929		36,929	16
17	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	62		62	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	6		6	18
19	V	25 Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	4,232		4,232	19
20	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	697		697	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	8,712		8,712	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	3,135		3,135	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	6,232		6,232	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	462		462	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%	459		459	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	<b>Total</b>		\$			\$ 61,177	\$ *	61,177	39

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

Facility Name & ID Number Rosiclare Rehabilitation & Health Care Center# 0047548Report Period Beginning: 1/1/2012Ending: 12/31/2012

## VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 Dietary	\$	Petersen Health Operations, LLC	100.00%	\$ 0	\$	15
16	V	2 Food		Petersen Health Operations, LLC	100.00%	0		16
17	V	3 Housekeeping		Petersen Health Operations, LLC	100.00%	0		17
18	V	4 Laundry		Petersen Health Operations, LLC	100.00%	0		18
19	V	5 Utilities		Petersen Health Operations, LLC	100.00%	0		19
20	V	6 Maintenance		Petersen Health Operations, LLC	100.00%	0		20
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	0		21
22	V	10 Nursing and Medical Records		Petersen Health Operations, LLC	100.00%	0		22
23	V	12 Social Services		Petersen Health Operations, LLC	100.00%	0		23
24	V	17 Administrative		Petersen Health Operations, LLC	100.00%	0		24
25	V	19 Professional Services		Petersen Health Operations, LLC	100.00%	58,647	58,647	25
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Operations, LLC	100.00%	39	39	26
27	V	21 Clerical and General Office		Petersen Health Operations, LLC	100.00%	995	995	27
28	V	22 Employee Benefits & Payroll		Petersen Health Operations, LLC	100.00%	0		28
29	V	23 Inservice Training & Education		Petersen Health Operations, LLC	100.00%	0		29
30	V	24 Travel and Seminar		Petersen Health Operations, LLC	100.00%	0		30
31	V	25 Other Admin. Staff Transport.		Petersen Health Operations, LLC	100.00%	38	38	31
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Operations, LLC	100.00%	0		32
33	V	27 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	0		33
34	V	30 Depreciation		Petersen Health Operations, LLC	100.00%	78	78	34
35	V	32 Interest		Petersen Health Operations, LLC	100.00%	44,056	44,056	35
36	V	33 Real Estate Taxes		Petersen Health Operations, LLC	100.00%	0		36
37	V	34 Rent-Facility and Grounds		Petersen Health Operations, LLC	100.00%	0		37
38	V	35 Rent-Equipment & Vehicles		Petersen Health Operations, LLC	100.00%	50	50	38
39	Total		\$			\$ 103,903	\$ * 103,903	39

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

Facility Name &amp; ID Number

Rosiclare Rehabilitation &amp; Health Care Center

# 0047548

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

Rosiclare Rehabilitation &amp; Health Care Center

# 0047548

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

Rosiclare Rehabilitation &amp; Health Care Center

# 0047548

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

Rosiclare Rehabilitation & Health Care Center

# 0047548

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 Rosiclare Rehabilitation & Health Care Cen # 0047548 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 Rosiclare Rehabilitation & Health Care Center

# 0047548

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	17,921	\$ 3,263	1
2	2	Food	Resident Days	1,569,393	74	9,632	0	17,921	110	2
3	3	Housekeeping	Resident Days	1,569,393	74	2,201	0	17,921	25	3
4	4	Laundry	Resident Days	1,569,393	74	397	0	17,921	5	4
5	5	Utilities	Resident Days	1,569,393	74	22,546	0	17,921	257	5
6	6	Maintenance	Resident Days	1,569,393	74	158,485	73,431	17,921	1,810	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,569,393	74	38,057	0	17,921	435	7
8	10	Nursing and Medical Records	Resident Days	1,569,393	74	2,750	0	17,921	31	8
9	10A	Therapy	Resident Days	1,569,393	74	0	0	17,921	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,569,393	74	0	0	17,921	0	10
11	17	Administrative	Resident Days	1,569,393	74	4,353,655	4,353,655	17,921	71,685	11
12	19	Professional Services	Resident Days	1,569,393	74	1,543,275	0	17,921	17,623	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,569,393	74	21,988	0	17,921	251	13
14	21	Clerical and General Office	Resident Days	1,569,393	74	3,233,970	2,816,787	17,921	36,929	14
15	23	Inservice Training & Education	Resident Days	1,569,393	74	5,397	0	17,921	62	15
16	24	Travel and Seminar	Resident Days	1,569,393	74	535	0	17,921	6	16
17	25	Other Admin. Staff Transport.	Resident Days	1,569,393	74	370,568	0	17,921	4,232	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,569,393	74	61,077	0	17,921	697	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,569,393	74	762,912	0	17,921	8,712	19
20	30	Depreciation	Resident Days	1,569,393	74	274,514	0	17,921	3,135	20
21	32	Interest	Resident Days	1,569,393	74	545,764	0	17,921	6,232	21
22	33	Real Estate Taxes	Resident Days	1,569,393	74	40,424	0	17,921	462	22
23	34	Rent-Facility and Grounds	Resident Days	1,569,393	74	0	0	17,921	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,569,393	74	40,223	0	17,921	459	24
25	TOTALS					\$ 11,774,077	\$ 7,528,087		\$ 156,421	25

Facility Name & ID Number Rosiclare Rehabilitation & Health Care Center

# 0047548

Report Period Beginning:

1/1/2012

Ending: 2/31/2012

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	404,785	21		17,921		1
2	2	Food	Resident Days	404,785	21		17,921		2
3	3	Housekeeping	Resident Days	404,785	21		17,921		3
4	4	Laundry	Resident Days	404,785	21		17,921		4
5	5	Utilities	Resident Days	404,785	21		17,921		5
6	6	Maintenance	Resident Days	404,785	21		17,921		6
7	7	Mgmt. Allocation of Benefits	Resident Days	404,785	21		17,921		7
8	10	Nursing and Medical Records	Resident Days	404,785	21		17,921		8
9	12	Social Services	Resident Days	404,785	21		17,921		9
10	17	Administrative	Resident Days	404,785	21		17,921		10
11	19	Professional Services	Resident Days	404,785	21	1,324,676	17,921	58,647	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	404,785	21	876	17,921	39	12
13	21	Clerical and General Office	Resident Days	404,785	21	22,478	17,921	995	13
14	22	Employee Benefits & Payroll	Resident Days	404,785	21		17,921		14
15	23	Inservice Training & Education	Resident Days	404,785	21		17,921		15
16	24	Travel and Seminar	Resident Days	404,785	21		17,921		16
17	25	Other Admin. Staff Transport.	Resident Days	404,785	21	849	17,921	38	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	404,785	21		17,921		18
19	27	Mgmt. Allocation of Benefits	Resident Days	404,785	21		17,921		19
20	30	Depreciation	Resident Days	404,785	21	1,761	17,921	78	20
21	32	Interest	Resident Days	404,785	21	995,096	17,921	44,056	21
22	33	Real Estate Taxes	Resident Days	404,785	21		17,921		22
23	34	Rent-Facility and Grounds	Resident Days	404,785	21		17,921		23
24	35	Rent-Equipment & Vehicles	Resident Days	404,785	21	1,130	17,921	50	24
25	TOTALS					\$ 2,346,866	\$	\$ 103,903	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	Reporting Period Interest Expense				
		Related**					Monthly Payment Required	Date of Note					Amount of Note		Maturity Date	Interest Rate (4 Digits)
		YES	NO										Original	Balance		
<b>A. Directly Facility Related</b>																
<b>Long-Term</b>																
1	Bank of America		X	Mortgage	Varies	1/19/07	\$ 3,500,000	\$ 3,274,784	12/31/13	Varies	\$ 271,907	1				
2												2				
3												3				
4												4				
5												5				
<b>Working Capital</b>																
6												6				
7												7				
8												8				
9	<b>TOTAL Facility Related</b>						\$ 3,500,000	\$ 3,274,784			\$ 271,907	9				
<b>B. Non-Facility Related*</b>																
10												10				
11											(834)	11				
12											6,232	12				
13											44,056	13				
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ 49,454	14				
15	<b>TOTALS (line 9+line14)</b>						\$ 3,500,000	\$ 3,274,784			\$ 321,361	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.				\$	5,640	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			\$	5,392	2														
3. Under or (over) accrual (line 2 minus line 1).				\$	(248)	3														
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	5,556	4														
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>				\$		5														
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.																				
<b>TOTAL REFUND</b>	\$	For	Tax Year.																	
				\$	462	6														
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	5,770	7														
Real Estate Tax History:																				
Real Estate Tax Bill for Calendar Year:	2007	4,934	8	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2" style="text-align: center;"><b>FOR BHF USE ONLY</b></td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2011 \$</td> <td style="text-align: center;">13</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td style="text-align: center;">14</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td style="text-align: center;">15</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td style="text-align: center;">16</td> </tr> </table>			<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
<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																		
	2008	5,162	9																	
	2009	5,281	10																	
	2010	5,412	11																	
	2011	5,392	12																	
<b>Accrual based on prior year tax bill.</b>																				

**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: 12,600 B. General Construction Type: Exterior Masonry Frame Metal 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>304,920</u>	<u>2005</u>	<u>\$ 74,250</u>	1
2					2
3	<b>TOTALS</b>	<b>304,920</b>		<b>\$ 74,250</b>	3

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	62	2005	1975	\$ 1,347,250	\$	25	\$ 53,890	\$ 53,890	\$ 350,285	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Original Land Improvements	2005		15,000		15	1,000	1,000	7,500	9
10	Sidewalks	2006		1,600		15	107	107	695	10
11	Sidewalks	2007		2,400		15	160	160	880	11
12	Parking Lot Resurfacing	2008		15,063		39	386	386	1,737	12
13	Heat Pump-5-Ton	2008		4,940		5	988	988	4,446	13
14	Sprinkler System Repair	2008		16,695		39	428	428	1,926	14
15	Sprinkler System Repair	2008		14,500		39	372	372	1,674	15
16	Dry Pendant Installation (23)	2008		2,812		20	140	140	630	16
17	Sprinkler System Repair	2009		16,205		7	2,316	2,316	8,106	17
18	Nurse Call System	2010		7,905		10	790	790	1,975	18
19										19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30	Land Improvements Booked				1,653			(1,653)		30
31	Building Booked				53,927			(53,927)		31
32	Building Improvement Booked				5,034			(5,034)		32
33										33
34	2012-Home Office Allocation-Land Improvements			782			50	50		34
35	2012-Home Office Allocation-Building Improvements			8,381			201	201		35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Rosiclare Rehabilitation & Health Care Center

# 0047548

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

**XI. OWNERSHIP COSTS (continued)**

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

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	<b>TOTAL (lines 4 thru 69)</b>		\$ 1,453,533	\$ 60,614		\$ 60,828	\$ 214	\$ 379,854	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	\$ 274,053	\$ 29,230	\$ 18,038	\$ (11,192)	5-10 yrs.	\$ 266,388	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Home Office Allocation			2,962	2,962			74
75	TOTALS	\$ 274,053	\$ 29,230	\$ 21,000	\$ (8,230)		\$ 266,388	75

D. Vehicle Costs. (See instructions.)\*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,801,836	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 89,844	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 81,828	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (8,016)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 646,242	85

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

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

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	<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: \$ 17,325 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	Ford E250 Van	\$ 828.41	\$ 11,560	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$ 828.41	\$ 11,560	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.

**Rosiclare Rehabilitation & Health Care Center**

**0047548**

**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	\$	11,667
Dishwasher		731
Laundry Equipment		-
Copier		4,418
Home Office Allocation		509
		<u>17,325</u>

Facility Name & ID Number Rosiclare Rehabilitation & Health Care Center # 0047548 Report Period Beginning: 1/1/2012 Ending: 12/31/2012  
**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)**

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<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	\$	7,765	\$ 116,474	\$	7,765	\$ 116,474	1	
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		4,692	70,383		4,692	70,383	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		9,376	140,639	23	9,376	140,662	4	
5	Physician Care		visits							5	
6	Dental Care		visits							6	
7	Work Related Program		hrs							7	
8	Habilitation		hrs							8	
9	Pharmacy	39(2)	# of prescripts				74,136		74,136	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify):									12	
13	Other (specify): <u>Respiratory Therapy</u>	10A(3)			11	165		11	165	13	
14	<b>TOTAL</b>			\$	21,844	\$ 327,661	\$ 74,159	21,844	\$ 401,820	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 Rosiclare Rehabilitation & Health Care Center# 0047548Report Period Beginning: 1/1/2012

Ending:

12/31/2012

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2012

(last day of reporting year)

This report must be completed even if f 2,206,296

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 4,379,780	\$ 4,379,780	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>20,000</u> )	769,727	769,727	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	19,265	19,265	6
7	Other Prepaid Expenses	8,794	8,794	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Security Deposit/PPD Lease</u>	6,806	6,806	9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 5,184,372	\$ 5,184,372	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		74,250	13
14	Buildings, at Historical Cost	1,455,563	1,355,631	14
15	Leasehold Improvements, at Historical Cost	63,057	97,902	15
16	Equipment, at Historical Cost	274,052	274,053	16
17	Accumulated Depreciation (book methods)	(688,215)	(646,242)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 1,104,457	\$ 1,155,594	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 6,288,829	\$ 6,339,966	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 650,240	\$ 650,240	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	19,357	19,357	30
31	Accrued Taxes Payable (excluding real estate taxes)	14,531	14,531	31
32	Accrued Real Estate Taxes(Sch.IX-B)	5,556	5,556	32
33	Accrued Interest Payable	9,035	9,035	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Payroll Withholdings</u>	16,346	16,346	36
37	<u>Accrued Management Fees</u>	143,821	143,821	37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 858,886	\$ 858,886	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable	3,274,784	3,274,784	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</b> (sum of lines 39 thru 44)	\$ 3,274,784	\$ 3,274,784	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 4,133,670	\$ 4,133,670	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 2,155,159	\$ 2,206,296	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 6,288,829	\$ 6,339,966	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,161,230	1
2	Restatements (describe):		2
3	Rounding		3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,161,230	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(6,071)	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)	\$ (6,071)	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)	\$ 2,155,159	24 *

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

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note:** This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,381,180	1
2	Discounts and Allowances for all Levels	(257,606)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 2,123,574</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	496,344	6
7	Oxygen	930	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 497,274</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	2,886	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	116,597	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	10,871	20
21	Other Medical Services	3,376	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 133,730</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	834	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 834</b>	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Miscellaneous Revenue	77	28
28a	Transportation Revenue	13,105	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 13,182</b>	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 2,768,594</b>	30

		2	
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	413,616	31
32	Health Care	1,137,382	32
33	General Administration	532,866	33
<b>B. Capital Expense</b>			
34	Ownership	395,435	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	105,742	35
36	Provider Participation Fee	189,624	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>\$ 2,774,665</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(6,071)</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (6,071)</b>	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,555,087	44
45	Private Pay - Net Inpatient Revenue	231,476	45
46	Medicare - Net Inpatient Revenue	345,886	46
47	Other-(specify) <u>Charity Therapy Allowance</u>	(6,935)	47
48	Other-(specify) <u>Insurance and Veterans Contractual Allow</u>	(1,940)	48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	<b>\$ 2,123,574</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 Rosiclare Rehabilitation & Health Care Center

# 0047548

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	2,038	2,038	\$ 61,164	\$ 30.01	1
2	Assistant Director of Nursing	1,931	2,067	51,554	24.94	2
3	Registered Nurses	7,221	7,575	155,537	20.53	3
4	Licensed Practical Nurses	7,278	7,710	113,190	14.68	4
5	CNAs & Orderlies	29,311	30,363	279,359	9.20	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,900	2,049	23,103	11.28	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,038	2,038	28,971	14.22	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,750	7,990	68,084	8.52	15
16	Dishwashers					16
17	Maintenance Workers	2,012	2,074	28,268	13.63	17
18	Housekeepers	1,820	2,038	71,013	34.84	18
19	Laundry	2,237	2,348	20,123	8.57	19
20	Administrator	2,080	2,080	71,685	34.46	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,904	2,066	31,027	15.02	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: Care Plan Coord	2,038	2,038	38,634	18.96	32
33	Other(specify) <u>Transportation</u>	1,685	1,798	15,713	8.74	33
34	TOTAL (lines 1 - 33)	73,243	76,272	\$ 1,057,425 *	\$ 13.86	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	65	\$ 3,289	L1, C3	35
36	Medical Director	Monthly	4,400	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,471	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)	65	\$ 11,160		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	
Lucinda Spivey	Administrator	0	\$ 71,685	Workers' Compensation Insurance	\$ 24,141	IDPH License Fee	\$ 3,980	
				Unemployment Compensation Insurance	26,504	Advertising: Employee Recruitment	284	
				FICA Taxes	77,660	Health Care Worker Background Check		
				Employee Health Insurance	7,145	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks	63	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	393	
				Employee Relations	452	Home Office Allocation	290	
				Employee Retirement	215			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 71,685	TOTAL (agree to Schedule V, line 22, col.8)		\$ 5,579		
B. Administrative - Other							Less: Public Relations Expense ( )	
Description			Amount				Non-allowable advertising ( )	
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 208,400				Yellow page advertising ( )	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 208,400	TOTAL (agree to Sch. V, line 20, col. 8)			\$ 5,579	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
E-Health Data Solutions	Computer Services		\$ 1,460	N/A			Out-of-State Travel	\$
Shawnee Communications	Computer Services		360				In-State Travel	
Honkamp Krueger & Co.	Accounting Fees		145				Seminar Expense	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 1,965	TOTAL		\$	Home Office Allocation	6
							Entertainment Expense ( )	
							TOTAL (agree to Sch. V, line 24, col. 8)	\$ 6

\* Attach copy of IMRF notifications

\*\*See instructions.

**Rosiclare Rehabilitation & Health Care Center**

**0047548**

**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)		1,965

**Home Office Allocation**

Sorling Northrup	Legal	56
Ginoli & Company	Accountants	2,005
Miscellaneous	Computer Services	46
Nebo Systems	Computer Services	2
Advanced Answers on Demand	Computer Services	2723
Access 2 Go	Computer Services	115
Stratus Networks	Computer Services	113
Kemper Technology	Computer Services	186
CCH	Computer Services	10
Medifax	Computer Services	22
Vision Share/Ability Network	Computer Services	208
Barracuda	Computer Services	7
CIAN	Computer Services	56
Comcast	Computer Services	18
Postini	Computer Services	176
Optimizer Systems	Other Prof Fees	28
Marotta Gund Budd & Dzera	Other Prof Fees	69844
David Budde	Other Prof Fees	11
Courtney Bourban	Other Prof Fees	155
All Scripts	Other Prof Fees	475
Heritage Enterprises	Other Prof Fees	11
Miscellaneous Vendors	Other Prof Fees	3

Total (agree to Schedule V, line 19, column 8)	<u><u>78,235</u></u>
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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 Rosiclare Rehabilitation &amp; Health Care Center

# 0047548

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. \$ 13,454 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. \$ 189,624  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,886
- (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. \$ 13,105
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Ginoli & Company
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? No  
Attach invoices and a summary of services for all architect and appraisal fees.

RECONCILIATION REPORT

Template

09:26 AM 6/14/2013

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	-7,813	equal to	-7,813	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	321,361	equal to	321,361	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	5,770	equal to	5,770	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	81,828	equal to	81,828	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	28,885	equal to	28,885	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	327,684	equal to	327,684	0	O.K.	Pg16 Z12+Z14..	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv.- Supplies	74,159	equal to	74,159	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	413,616	equal to	413,616	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	1,137,382	equal to	1,137,382	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	532,866	equal to	532,866	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	395,435	equal to	395,435	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	105,742	equal to	105,742	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+t	N/A	38to41+43	4
Income Stat. Prov. Partic.	189,624	equal to	189,624	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	699,438	equal to	699,438	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	38,816	equal to	38,816	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	0	equal to		0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	97,055	equal to	97,055	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	28,268	equal to	28,268	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	71,013	equal to	71,013	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	20,123	equal to	20,123	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	71,685	equal to		0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	31,027	equal to	31,027	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	1,057,425	equal to	985,740	71,685	FAILED	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	3,289	< or = to	3,289	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	4,400	< or = to	4,400	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	3,471	< or = to	4,139	-668	O.K.	Pg20 X14..X16+	B. & C.	i7to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to	-31	31	FAILED	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.	71,685	equal to		0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	208,400	equal to	208,400	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3

Supp. Sched.- Prof. Serv.	1,965	equal to	1,965	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	136,117	equal to	136,117	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	5,579	equal to	5,579	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	6	equal to	6	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	189,624	equal to	189,624	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	0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	1,921	equal to	2,037	-116	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	51,924	equal to	51,924	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4I	B.	14	8
Total loan balance	3,274,784	equal to	3,274,784	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	5,556	equal to	5,556	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	74,250	equal to	74,250	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	1,453,533	equal to	1,453,533	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	274,053	equal to	274,053	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	646,242	equal to	646,242	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	2,155,159	equal to	2,155,159	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	-6,071	equal to	-6,071	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to	0	0	O.K.	Pg22 F31-J31..§	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	6,288,829	equal to	6,288,829	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	97,055	7,886	3,289	108,230	0	108,230	3,263	111,493
2. Food Purchase	0	88,185	0	88,185	0	88,185	-2,776	85,409
3. Housekeeping	71,013	11,161	0	82,174	0	82,174	25	82,199
4. Laundry	20,123	5,580	0	25,703	0	25,703	5	25,708
5. Heat and Other Utilities	0	0	60,504	60,504	0	60,504	257	60,761
6. Maintenance	28,268	5,514	15,038	48,820	0	48,820	1,810	50,630
7. Other (specify)*	0	0	0	0	0	0	435	435
8. Total General Services	216,459	118,326	78,831	413,616	0	413,616	3,019	416,635
9. Medical Director	0	0	4,400	4,400	0	4,400	0	4,400
10. Nursing & Medical Records	699,438	62,901	4,139	766,478	0	766,478	31	766,509
10a. Therapy	0	23	327,661	327,684	0	327,684	0	327,684
11. Activities	38,816	15	-31	38,800	0	38,800	-13,105	25,695
12. Social Services	0	20	0	20	0	20	0	20
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	738,254	62,959	336,169	1,137,382	0	1,137,382	-13,074	1,124,308
17. Administrative	0	0	208,400	208,400	0	208,400	-136,715	71,685
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	1,965	1,965	0	1,965	76,270	78,235
20. Fees, Subscriptions & Promotion	0	0	5,289	5,289	0	5,289	290	5,579
21. Clerical & General Office	31,027	2,558	117,628	151,213	0	151,213	37,847	189,060
22. Employee Benefits & Payroll	0	0	136,117	136,117	0	136,117	0	136,117
23. Inservice Training & Education	0	0	0	0	0	0	62	62
24. Travel and Seminar	0	0	0	0	0	0	6	6
25. Other Admin. Staff Trans	0	0	10,462	10,462	0	10,462	4,270	14,732
26. Insurance-Prop.Liab.Malpractice	0	0	19,420	19,420	0	19,420	697	20,117
27. Other (specify)*	0	0	0	0	0	0	8,712	8,712
28. Total General Adminis	31,027	2,558	499,281	532,866	0	532,866	-8,561	524,305
29. Total General Administrative	985,740	183,843	914,281	2,083,864	0	2,083,864	-18,616	2,065,248
30. Depreciation	0	0	89,844	89,844	0	89,844	-8,016	81,828
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	271,907	271,907	0	271,907	49,454	321,361
33. Real Estate	0	0	5,308	5,308	0	5,308	462	5,770

34. Rent - Facility & Grounds	0	0	0	0	0	0	0	0
35. Rent - Equipment & Vehicles	0	0	28,376	28,376	0	28,376	509	28,885
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	395,435	395,435	0	395,435	42,409	437,844
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	74,136	0	74,136	0	74,136	0	74,136
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	189,624	189,624	0	189,624	0	189,624
43. Other (specify):*	0	54	31,552	31,606	0	31,606	-31,606	0
44. Total Special Cost Ce	0	74,190	221,176	295,366	0	295,366	-31,606	263,760
45. Grand Total	985,740	258,033	1,530,892	2,774,665	0	2,774,665	-7,813	2,766,852

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	4,379,780	4,379,780
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	769,727	769,727
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	19,265	19,265
7. Other Prepaid Expenses	8,794	8,794
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	6,806	6,806
10. Total current assets	5,184,372	5,184,372
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	0	74,250
14. Buildings, at Historical Cost	1,455,563	1,355,631
15. Leasehold Improvements, Historical Cost	63,057	97,902
16. Equipment, at Historical Cost	274,052	274,053
17. Accumulated Depreciation (book methods)	-688,215	-646,242
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):	0	0
23. other (specify):	0	0
24. Total Long-Term Assets	1,104,457	1,155,594
25. Total Assets	6,288,829	6,339,966
CURRENT LIABILITIES		
26. Accounts Payable	650,240	650,240
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	19,357	19,357
31. Accrued Taxes Payable	14,531	14,531
32. Accrued Real Estate Taxes	5,556	5,556
33. Accrued Interest Payable	9,035	9,035
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	16,346	16,346

37. Other Current Liabilities (specify):	143,821	143,821
38. Total Current Liabilities	858,886	858,886
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	3,274,784	3,274,784
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	3,274,784	3,274,784
46.Total Liabilities	4,133,670	4,133,670
47.Total Equity	2,155,159	2,206,296
48.Total Liabilities and Equity	6,288,829	6,339,966

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	2,381,180
2. Discounts and Allowances for all Levels	-257,606
Subtotal - Inpatient Care	2,123,574
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	496,344
7. Oxygen	930
Subtotal - Anciliary Revenue	497,274
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	2,886
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	116,597
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiology and X-Ray	10,871
21. Other Medical Services	3,376
22. Laundry	0
Subtotal - Other Operating Revenue	133,730
24. Contributions	0
25. Interest and Other Investments Income	834
Subtotal - Non-Operating Revenue	834
27. Other Revenue (specify):	0
28. Other Revenue (specify):	13,182
Subtotal - Other Revenue	13,182
30. Total Revenue	2,768,594
31. General Services	411,031
32. Health Care	1,160,175
33. General Administration	458,558
34. Ownership	302,097

35. Special Cost Centers	170,375
35. Provider Participation Fee	33,945
37. Other	0
40. Total Expenses	2,536,181
41. Income Before Income Taxes	232,413
42. Income Taxes	0
43. Net Income or Loss for the Year	232,413

Enter Cost Center Expenses

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

6/14/2013 09:26:55 AM

HSA Number: \_\_\_\_\_ 5 Name: Rosiclare Rehabilitation & Health Care 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: 22,630 Occupancy: N 17,921 Pct. of occupancy: 79.19%

Illinois Public Aid Support Rate: \$ \_\_\_\_\_

Genl Services Salary/Wage: 216,459 Col 1, Line 8 ---Audit Adj: \_\_\_\_\_

Genl Admin Salary/Wage: 31,027 Col 1, Line 28 ---Audit Adj: \_\_\_\_\_

Total Salary Wage: 985,740 Col 1, Line 44 ---Audit Adj: \_\_\_\_\_

Employee Benefits: 136,117 Col 8, Line 22 ---Audit Adj: \_\_\_\_\_

Total General Services: 416,635 Col 8, Line 8 ---Audit Adj: \_\_\_\_\_

Total General Admin: 524,305 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 you 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

\$216,459  
\$985,740  
 21.9590%  
\$136,117  
  
 \$29,890  
\$416,635  
\$446,525

\$31,027  
\$985,740  
 3.1476%

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

\$136,117  
\$4,284  
\$524,305  
\$136,117  
\$392,472

6.5  
0.526315789  
1344

1351.026316  
907.00

444

1  
1

\$446,525  
1

\$446,525

\$392,472  
1  
\$392,472  
\$838,997

\$44.24

\$838,997  
17,921  
\$46.82

22,630  
0.93  
21,046

17,921  
3,125

1,042

17,921

18,963

\$838,997  
18963  

---

\$44.24

\$41.31  
\$44.24  
-\$2.93  

---

0.5  
-\$1.47  

---

\$44.24  

---

42.77

\$41.31  
\$44.24  
-\$2.93

0.5

-\$1.47

3.645

-\$1.470

\$44.24

\$42.77

**\$41.31**

\$41.31

\$34.45

7/DD 16 Facilities)

Centiles 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