

Facility Name & ID Number Collinsville Rehab & Hlth CC

0048447 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	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	100	Skilled (SNF)	100	36,500	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	100	TOTALS	100	36,500	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	17,121	1,944	1,405	20,470	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,121	1,944	1,405	20,470	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 56.08%

D. How many bed-hold days during this year were paid by the Department? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES 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 7/25/06

J. Was the facility purchased or leased after January 1, 1978?
YES Date 7/25/2006 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 100 and days of care provided 1,321

Medicare Intermediary Wisconsin Physicians Service

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2013 Fiscal Year: 12/31/2013

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	112,983	13,080	1,006	127,069		127,069	4,034	131,103		1
2	Food Purchase		122,184		122,184		122,184	(1,729)	120,455		2
3	Housekeeping	84,483	27,855		112,338		112,338	40	112,378		3
4	Laundry	57,556	10,507		68,063		68,063		68,063		4
5	Heat and Other Utilities			60,764	60,764		60,764	306	61,070		5
6	Maintenance	35,455	16,159	14,554	66,168		66,168	1,976	68,144		6
7	Other (specify):* Home Off. Ben. All.							228	228		7
8	TOTAL General Services	290,477	189,785	76,324	556,586		556,586	4,855	561,441		8
	B. Health Care and Programs										
9	Medical Director			13,200	13,200		13,200		13,200		9
10	Nursing and Medical Records	951,849	86,828	5,805	1,044,482		1,044,482	(962)	1,043,520		10
10a	Therapy			194,791	194,791		194,791		194,791		10a
11	Activities	35,680	23	380	36,083		36,083	(12,054)	24,029		11
12	Social Services	34,380	67		34,447		34,447		34,447		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.										15
16	TOTAL Health Care and Programs	1,021,909	86,918	214,176	1,323,003		1,323,003	(13,016)	1,309,987		16
	C. General Administration										
17	Administrative			145,100	145,100		145,100	(77,300)	67,800		17
18	Directors Fees										18
19	Professional Services			81,438	81,438		81,438	15,426	96,864		19
20	Dues, Fees, Subscriptions & Promotions			4,873	4,873		4,873	3,368	8,241		20
21	Clerical & General Office Expenses	27,450	5,146	12,146	44,742		44,742	55,843	100,585		21
22	Employee Benefits & Payroll Taxes			204,897	204,897		204,897		204,897		22
23	Inservice Training & Education			395	395		395	81	476		23
24	Travel and Seminar							4	4		24
25	Other Admin. Staff Transportation			6,890	6,890		6,890	3,734	10,624		25
26	Insurance-Prop.Liab.Malpractice			37,174	37,174		37,174	721	37,895		26
27	Other (specify):* Home Off. Ben. All.							4,627	4,627		27
28	TOTAL General Administration	27,450	5,146	492,913	525,509		525,509	6,504	532,013		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,339,836	281,849	783,413	2,405,098		2,405,098	(1,657)	2,403,441		29

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

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

Facility Name & ID Number

Collinsville Rehab & Hlth CC

#0048447

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			100,418	100,418		100,418	1,226	101,644			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			79,297	79,297		79,297	33,657	112,954			32
33	Real Estate Taxes			33,981	33,981		33,981	324	34,305			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			35,521	35,521		35,521	597	36,118			35
36	Other (specify):*											36
37	TOTAL Ownership			249,217	249,217		249,217	35,804	285,021			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		72,821		72,821		72,821		72,821			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			167,899	167,899		167,899		167,899			42
43	Other (specify):* Non-allowable Costs		438	91,753	92,191		92,191	(92,191)				43
44	TOTAL Special Cost Centers		73,259	259,652	332,911		332,911	(92,191)	240,720			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,339,836	355,108	1,292,282	2,987,226		2,987,226	(58,044)	2,929,182			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,815)	2		4
5	Telephone, TV & Radio in Resident Rooms	(11,082)	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	(7,795)	30		9
10	Interest and Other Investment Income	(30,867)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(99)	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	(24,805)	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	(42,379)	43		24
25	Fund Raising, Advertising and Promotional	(1,435)	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	(25,505)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (145,782)		\$	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)	87,738	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 87,738		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (58,044)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4
		Yes	No	Amount	Reference
38	Medically Necessary Transport.		X	\$	38
39					39
40	Gift and Coffee Shops		X		40
41	Barber and Beauty Shops		X		41
42	Laboratory and Radiology		X		42
43	Prescription Drugs		X		43
44					44
45	Other-Attach Schedule		X		45
46	Other-Attach Schedule		X		46
47	TOTAL (C): (sum of lines 38-46)			\$	47

Collinsville Rehab & Hlth CC

ID# 0048447

Report Period Beginning: 1/1/2013

Ending: 12/31/2013

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Labs-Part A	\$ (5,388)	43	1
2	X-Rays-Part A	(6,291)	43	2
3	Offset Transportation Revenue	(12,054)	11	3
4	Offset Miscellaneous Office Supplies Revenue	(84)	21	4
5	Disallowed Special Events	(98)	43	5
6	Resident Flower	(614)	43	6
7	Offset Miscellaneous Nursing Supplies Revenue	(976)	10	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		(25,505)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Collinsville Rehab & Hlth CC

0048447

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	4,034	0	0	0	0	0	0	0	0	0	4,034	1
2	Food Purchase	(1,815)	86	0	0	0	0	0	0	0	0	0	(1,729)	2
3	Housekeeping	0	40	0	0	0	0	0	0	0	0	0	40	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	306	0	0	0	0	0	0	0	0	0	306	5
6	Maintenance	0	1,976	0	0	0	0	0	0	0	0	0	1,976	6
7	Other (specify):*	0	228	0	0	0	0	0	0	0	0	0	228	7
8	TOTAL General Services	(1,815)	6,670	0	0	0	0	0	0	0	0	0	4,855	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(976)	14	0	0	0	0	0	0	0	0	0	(962)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(12,054)	0	0	0	0	0	0	0	0	0	0	(12,054)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(13,030)	14	0	0	0	0	0	0	0	0	0	(13,016)	16
	C. General Administration													
17	Administrative	0	(77,300)	0	0	0	0	0	0	0	0	0	(77,300)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	8,504	0	6,922	0	0	0	0	0	0	0	15,426	19
20	Fees, Subscriptions & Promotions	0	0	541	2,827	0	0	0	0	0	0	0	3,368	20
21	Clerical & General Office Expenses	(84)	0	49,989	5,938	0	0	0	0	0	0	0	55,843	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	81	0	0	0	0	0	0	0	0	81	23
24	Travel and Seminar	0	0	4	0	0	0	0	0	0	0	0	4	24
25	Other Admin. Staff Transportation	0	0	3,734	0	0	0	0	0	0	0	0	3,734	25
26	Insurance-Prop.Liab.Malpractice	0	0	721	0	0	0	0	0	0	0	0	721	26
27	Other (specify):*	0	0	4,627	0	0	0	0	0	0	0	0	4,627	27
28	TOTAL General Administration	(84)	(68,796)	59,697	15,687	0	6,504	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(14,929)	(62,112)	59,697	15,687	0	(1,657)	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Collinsville Rehab & Hlth CC# 0048447

Report Period Beginning:

1/1/2013 Ending:

12/31/2013

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(7,795)	0	3,314	5,707	0	0	0	0	0	0	0	1,226	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(30,867)	0	5,512	59,012	0	0	0	0	0	0	0	33,657	32
33	Real Estate Taxes	0	0	324	0	0	0	0	0	0	0	0	324	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	597	0	0	0	0	0	0	0	0	597	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(38,662)	0	9,747	64,719	0	35,804	37						
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(92,191)	0	0	0	0	0	0	0	0	0	0	(92,191)	43
44	TOTAL Special Cost Centers	(92,191)	0	0	0	0	0	0	0	0	0	0	(92,191)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(145,782)	(62,112)	69,444	80,406	0	0	0	0	0	0	0	(58,044)	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	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)	
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 4,034	\$ 4,034	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	86	86	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	40	40	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	306	306	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	1,976	1,976	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	228	228	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	14	14	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	145,100	Petersen Health Care, Inc.	100.00%	67,800	(77,300)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	8,504	8,504	12
13	V							13
14	Total		\$ 145,100			\$ 82,988	\$ * (62,112)	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%	\$ 541	\$	541	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	49,989		49,989	16
17	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	81		81	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	4		4	18
19	V	25 Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	3,734		3,734	19
20	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	721		721	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	4,627		4,627	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	3,314		3,314	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	5,512		5,512	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	324		324	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%	597		597	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 69,444	\$ *	69,444	39

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

Facility Name & ID Number Collinsville Rehab & Hlth CC# 0048447Report Period Beginning: 1/1/2013Ending: 12/31/2013

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. 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	\$		100.00%	\$ 0	\$	15	
16	V	2 Food			100.00%	0		16	
17	V	3 Housekeeping			100.00%	0		17	
18	V	4 Laundry			100.00%	0		18	
19	V	5 Utilities			100.00%	0		19	
20	V	6 Maintenance			100.00%	0		20	
21	V	7 Mgmt. Allocation of Benefits			100.00%	0		21	
22	V	10 Nursing and Medical Records			100.00%	0		22	
23	V	12 Social Services			100.00%	0		23	
24	V	17 Administrative			100.00%	0		24	
25	V	19 Professional Services			100.00%	6,922	6,922	25	
26	V	20 Dues, Fees, Subs & Promotions			100.00%	2,827	2,827	26	
27	V	21 Clerical and General Office			100.00%	5,938	5,938	27	
28	V	22 Employee Benefits & Payroll			100.00%	0		28	
29	V	23 Inservice Training & Education			100.00%	0		29	
30	V	24 Travel and Seminar			100.00%	0		30	
31	V	25 Other Admin. Staff Transport.			100.00%	0		31	
32	V	26 Insurance-Prop./Liab./Malprac.			100.00%	0		32	
33	V	27 Mgmt. Allocation of Benefits			100.00%	0		33	
34	V	30 Depreciation			100.00%	5,707	5,707	34	
35	V	32 Interest			100.00%	59,012	59,012	35	
36	V	33 Real Estate Taxes			100.00%	0		36	
37	V	34 Rent-Facility and Grounds			100.00%	0		37	
38	V	35 Rent-Equipment & Vehicles			100.00%	0		38	
39	Total		\$			\$ 80,406	\$ *	80,406	39

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

Facility Name & ID Number

Collinsville Rehab & Hlth CC

0048447

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Aledo Health Care Center	Aledo	Petersen Companies, I	Peoria	Mgmt/Bookkeeping	1
2			Arcola Health Care Center	Arcola	Petersen Health Care J	Peoria	Mgmt/Bookkeeping	2
3			Aspen Rehab & Health Care	Silvis	Petersen Health Care,	Peoria	Mgmt/Bookkeeping	3
4			Batavia Rehab & Health Care Center	Batavia	Petersen Health Enter	Peoria	Mgmt/Bookkeeping	4
5			Bement Health Care Center	Bement	Petersen Health Opera	Peoria	Mgmt/Bookkeeping	5
6			Benton Rehab & Health Care Center	Benton	Petersen Health Syste	Peoria	Mgmt/Bookkeeping	6
7			Bloomington Rehab & Health Care Center	Bloomington	Petersen Hotels LLC	Peoria	Hospitality	7
8			Casey Health Care Center	Casey	Petersen Restaurants,	Peoria	Restaurant	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Health Care	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Care	Peoria	Mgmt/Bookkeeping	11
12			Countryview Terrace	Louisville	Petersen Health Care	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care	Peoria	Mgmt/Bookkeeping	13
14			Decatur Rehab & Health Care Center	Decatur	Petersen Health Care	Peoria	Lessor	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Osage Beach,	Osage Beach, MO	Lessor	15
16			Eastview Terrace	Sullivan	Petersen West Frankf	West Frankfort	Lessor	16
17			El Paso Health Care Center	El Paso	Midwest Health Care,	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Poplar Bluff Health C	Poplar Bluff, MO	Lessor	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Roseville, LL	Roseville	Lessor	19
20			Flanagan Rehab & Health Care Center	Flanagan				20
21			Flora Gardens Care Center	Flora				21
22			Flora Health Care Center	Flora				22
23			Fondulac Rehab & Health Care Center	East Peoria				23
24			Havana Health Care Center	Havana				24
25			Illini Heritage Rehab & Health Care	Champaign				25
26			Jonesboro Rehab & Health Care Center	Jonesboro				26
27			Kewanee Care Home	Kewanee				27
28			LaHarpe Davier Health Care Center	LaHarpe				28
29			Lebanon Care Center	Lebanon				29
30			Marigold Rehab & Health Care Center	Galesburg				30

Facility Name & ID Number

Collinsville Rehab & Hlth CC

0048447

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

VII. RELATED PARTIES

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

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

Facility Name & ID Number

Collinsville Rehab & Hlth CC

0048447

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Toulon Health Care Center	Toulon				1
2			Tuscola Health Care Center	Tuscola				2
3			Twin Lakes Rehab & Health Care Center	Paris				3
4			Vandalia Rehab & Health Care Center	Vandalia				4
5			Watseka Health Care Center	Watseka				5
6			Westside Rehab & Care Center	West Frankfort				6
7			Whispering Oaks	Rosiclare				7
8			White Oak Rehab & Health Care Center	Mt. Vernon				8
9			Willow Rose Rehab & Health Care Center	Jerseyville				9
10			Sheldon Health Care Center	Sheldon				10
11			Tuscola Health Care Center	Tuscola				11
12			Effingham Health Care Center	Effingham				12
13			Collinsville Health Care Center	Collinsville				13
14			Ozark Rehab & Health Care Center	Osage Beach, MO				14
15			South Shore Health Care, LLC	Gary, IN				15
16			Cedargate Skilled Nursing Facility	Poplar Bluff, MO				16
17			Tarkio Rehab & Health Care Center	Tarkio, MO				17
18			Shangri-la Rehab & Living Center	Blue Springs, MO				18
19			Prairie Rose Care Center	Pana				19
20			Illini Heritage Rehab & Health Center	Champaign				20
21			Courtyard Estates of Kewanee	Kewanee				21
22			Courtyard Estates of Bradford	Bradford				22
23			Courtyard Estates of Galva	Galva				23
24			Courtyard Estates of Walcott	Walcott				24
25			Courtyard Village of Kewanee	Kewanee				25
26			Lakewood Village	Charleston				26
27			Courtyard Estates of Monmouth	Monmouth				27
28			Riverview Estates	Havana				28
29			Simple Blessings	Casey				29
30			Courtyard Estates of Bushnell	Bushnell				30

Facility Name & ID Number

Collinsville Rehab & Hlth CC

0048447

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Courtyard Estates of Canton	Canton				1
2			Legacy Estates of Monmouth	Monmouth				2
3			Courtyard Estates of Sullivan	Sullivan				3
4			Courtyard Estates of Peoria	Peoria				4
5			Cornerstone Health and Rehabilitation	Peoria				5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Collinsville Rehab & Hlth CC # 0048447 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 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 Collinsville Rehab & Hlth CC

0048447

Report Period Beginning:

1/1/2013

Ending: 2/31/2013

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES 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	1,560,986	75	\$ 307,592	\$ 295,212	20,470	\$ 4,034	1
2	2	Food	Resident Days	1,560,986	75	6,577	0	20,470	86	2
3	3	Housekeeping	Resident Days	1,560,986	75	3,057	0	20,470	40	3
4	4	Laundry	Resident Days	1,560,986	75	0	0	20,470	0	4
5	5	Utilities	Resident Days	1,560,986	75	23,338	0	20,470	306	5
6	6	Maintenance	Resident Days	1,560,986	75	150,672	97,358	20,470	1,976	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,560,986	75	17,394	0	20,470	228	7
8	10	Nursing and Medical Records	Resident Days	1,560,986	75	1,082	0	20,470	14	8
9	10A	Therapy	Resident Days	1,560,986	75	0	0	20,470	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,560,986	75	0	0	20,470	0	10
11	17	Administrative	Resident Days	1,560,986	75	4,578,456	4,578,456	20,470	67,800	11
12	19	Professional Services	Resident Days	1,560,986	75	648,504	0	20,470	8,504	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,560,986	75	41,231	0	20,470	541	13
14	21	Clerical and General Office	Resident Days	1,560,986	75	3,812,055	3,383,297	20,470	49,989	14
15	23	Inservice Training & Education	Resident Days	1,560,986	75	6,148	0	20,470	81	15
16	24	Travel and Seminar	Resident Days	1,560,986	75	313	0	20,470	4	16
17	25	Other Admin. Staff Transport.	Resident Days	1,560,986	75	284,745	0	20,470	3,734	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,560,986	75	54,993	0	20,470	721	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,560,986	75	352,851	0	20,470	4,627	19
20	30	Depreciation	Resident Days	1,560,986	75	252,711	0	20,470	3,314	20
21	32	Interest	Resident Days	1,560,986	75	420,365	0	20,470	5,512	21
22	33	Real Estate Taxes	Resident Days	1,560,986	75	24,742	0	20,470	324	22
23	34	Rent-Facility and Grounds	Resident Days	1,560,986	75	0	0	20,470	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,560,986	75	45,546	0	20,470	597	24
25	TOTALS					\$ 11,032,372	\$ 8,354,323		\$ 152,432	25

Facility Name & ID Number Collinsville Rehab & Hlth CC

0048447

Report Period Beginning:

1/1/2013

Ending: 2/31/2013

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Petersen Health Enterprises, 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	66,460	4		20,470		1
2	2	Food	Resident Days	66,460	4		20,470		2
3	3	Housekeeping	Resident Days	66,460	4		20,470		3
4	4	Laundry	Resident Days	66,460	4		20,470		4
5	5	Utilities	Resident Days	66,460	4		20,470		5
6	6	Maintenance	Resident Days	66,460	4		20,470		6
7	7	Mgmt. Allocation of Benefits	Resident Days	66,460	4		20,470		7
8	10	Nursing and Medical Records	Resident Days	66,460	4		20,470		8
9	15	Mgmt. Allocation of Benefits	Resident Days	66,460	4		20,470		9
10	17	Administrative	Resident Days	66,460	4		20,470		10
11	19	Professional Services	Resident Days	66,460	4	22,473	20,470	6,922	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	66,460	4	9,179	20,470	2,827	12
13	21	Clerical and General Office	Resident Days	66,460	4	19,278	20,470	5,938	13
14	22	Employee Benefits & Payroll	Resident Days	66,460	4		20,470		14
15	23	Inservice Training & Education	Resident Days	66,460	4		20,470		15
16	24	Travel and Seminar	Resident Days	66,460	4		20,470		16
17	25	Other Admin. Staff Transport.	Resident Days	66,460	4		20,470		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	66,460	4		20,470		18
19	27	Mgmt. Allocation of Benefits	Resident Days	66,460	4		20,470		19
20	30	Depreciation	Resident Days	66,460	4	18,529	20,470	5,707	20
21	32	Interest	Resident Days	66,460	4	191,593	20,470	59,012	21
22	33	Real Estate Taxes	Resident Days	66,460	4		20,470		22
23	34	Rent-Facility and Grounds	Resident Days	66,460	4		20,470		23
24	35	Rent-Equipment & Vehicles	Resident Days	66,460	4		20,470		24
25	TOTALS					\$ 261,052	\$	\$ 80,406	25

Facility Name & ID Number

Collinsville Rehab & Hlth CC

0048447

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10	11						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	First Bank		X	Mortgage	\$10,014.67	6/22/12	\$ 1,368,750	\$ 1,192,272	6/22/15	6.0000	\$ 79,297	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6												6						
7												7						
8												8						
9	TOTAL Facility Related				\$10,014.67		\$ 1,368,750	\$ 1,192,272			\$ 79,297	9						
B. Non-Facility Related*																		
10												10						
11											(30,867)	11						
12											5,512	12						
13											59,012	13						
14	TOTAL Non-Facility Related						\$	\$			\$ 33,657	14						
15	TOTALS (line 9+line14)						\$ 1,368,750	\$ 1,192,272			\$ 112,954	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

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

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

C. **Tax Bills**

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 29,350 B. General Construction Type: Exterior Brick Frame Steel 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:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Facility</u>	<u>391,343</u>	<u>2006</u>	<u>\$ 40,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	391,343		\$ 40,000	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	100	2006	1962	\$ 1,635,299	\$	30	\$ 54,510	\$ 54,510	\$ 408,825	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Wheelchair Ramp		2007	2,530		15	169	169	1,098	9
10	Fountain		2007	1,269		15	85	85	552	10
11	Exit Signs		2007	612		7	87	87	566	11
12	Blinds		2007	4,886		10	489	489	3,178	12
13	Exit Signs		2008	690		15	46	46	253	13
14	Boiler		2009	6,500		7	929	929	3,715	14
15	Sprinkler Repair		2009	22,880		7	3,268	3,268	14,706	15
16	Boiler		2010	11,339		15	756	756	2,646	16
17	A/C Unit		2010	6,260		15	418	418	1,463	17
18	Roof Replacement		2010	69,464		25	2,778	2,778	9,723	18
19	Nurse Call Light System		2011	6,260		10	626	626	1,565	19
20	Ceiling Repair		2011	2,575		7	368	368	920	20
21	Roof Replacement-Completion of 2010 Work		2011	44,923		25	1,796	1,796	4,490	21
22	Roof Repairs		2012	3,047		7	436	436	654	22
23	Roof and Gutter Replacement		2012	64,790		25	2,592	2,592	3,888	23
24	Roof Repairs		2013	9,793		7	700	700	700	24
25										25
26										26
27										27
28										28
29										29
30	Land Improvements Booked				253			(253)		30
31	Building Booked				65,634			(65,634)		31
32	Building Improvement Booked				13,586			(13,586)		32
33										33
34	2013-Home Office Allocation-Building Improvements			9,625			231	231		34
35	2013-Home Office Allocation-Land Improvements			898			57	57		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

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
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66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,903,640	\$ 79,473		\$ 70,341	\$ (9,132)	\$ 458,942	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	\$ 223,393	\$ 20,617	\$ 22,340	\$ 1,723	5-10 yrs.	\$ 159,096	71
72	Current Year Purchases	4,593	328	230	(98)	10 yrs.	230	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			8,733	8,733			74
75	TOTALS	\$ 227,986	\$ 20,945	\$ 31,303	\$ 10,358		\$ 159,326	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,171,626	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 100,418	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 101,644	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,226	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 618,268	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Collinsville Rehab & Hlth CC

0048447

Report Period Beginning: 1/1/2013

Ending: 12/31/2013

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

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

12. _____ /2014 \$ _____

13. _____ /2015 \$ _____

14. _____ /2016 \$ _____

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: \$ 29,656 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	2009 Ford E150	\$ 538.00	\$ 6,462	17
18					18
19					19
20					20
21	TOTAL		\$ 538.00	\$ 6,462	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.

**Collinsville Rehab & Hlth CC
0048447**

Period Beginning 1/1/2013
Period End 12/31/2013

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$ 23,386
Dishwasher	713
Laundry Equipment	-
Copier	4,960
Home Office Allocation	597
	<u>29,656</u>

Facility Name & ID Number Collinsville Rehab & Hlth CC # 0048447 Report Period Beginning: 1/1/2013 Ending: 12/31/2013
XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</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>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		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	\$	5,431	\$ 81,464	\$	5,431	\$ 81,464	1	
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2,528	37,922		2,528	37,922	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	10A(3)	hrs		5,020	75,295		5,020	75,295	4	
5	Physician Care		visits							5	
6	Dental Care		visits							6	
7	Work Related Program		hrs							7	
8	Habilitation		hrs							8	
9	Pharmacy	39(2)	# of prescrpts				72,821		72,821	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)			7	110		7	110	13	
14	TOTAL			\$	12,986	\$ 194,791	\$ 72,821	12,986	\$ 267,612	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 Collinsville Rehab & Hlth CC# 0048447Report Period Beginning: 1/1/2013

Ending:

12/31/2013

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2013

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (311,081)	\$ (311,081)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>240,217</u>)	776,156	776,156	3
4	Supply Inventory (priced at)	10,390	10,390	4
5	Short-Term Investments			5
6	Prepaid Insurance	35,036	35,036	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Security Deposit</u>	5,109	5,109	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 515,610	\$ 515,610	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	43,799	40,000	13
14	Buildings, at Historical Cost	1,635,299	1,644,924	14
15	Leasehold Improvements, at Historical Cost	204,211	258,716	15
16	Equipment, at Historical Cost	232,872	227,986	16
17	Accumulated Depreciation (book methods)	(745,287)	(618,268)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,370,894	\$ 1,553,358	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,886,504	\$ 2,068,968	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 495,645	\$ 495,645	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	79,100	79,100	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,976	7,976	31
32	Accrued Real Estate Taxes(Sch.IX-B)	42,684	42,684	32
33	Accrued Interest Payable	6,202	6,202	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	39,942	39,942	36
37	<u>Accrued Management Fees</u>	261,783	261,783	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 933,332	\$ 933,332	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,192,272	1,192,272	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Intercompany Loan</u>	509,218	509,218	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,701,490	\$ 1,701,490	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,634,822	\$ 2,634,822	46
47	TOTAL EQUITY(page 18, line 24)	\$ (748,318)	\$ (565,854)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,886,504	\$ 2,068,968	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (805,318)	1
2	Restatements (describe):		2
3	Rounding	(1)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (805,319)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	57,001	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)	\$ 57,001	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (748,318)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Collinsville Rehab & Hlth CC# 0048447Report Period Beginning: 1/1/2013Ending: 12/31/2013

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

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,740,951	1
2	Discounts and Allowances for all Levels	(200,295)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,540,656	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	327,814	6
7	Oxygen	25	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 327,839	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,815	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	113,604	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	9,285	20
21	Other Medical Services	7,047	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 131,751	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	30,867	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 30,867	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	1,060	28
28a	Transportation Revenue	12,054	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 13,114	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,044,227	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	556,586	31
32	Health Care	1,323,003	32
33	General Administration	525,509	33
B. Capital Expense			
34	Ownership	249,217	34
C. Ancillary Expense			
35	Special Cost Centers	165,012	35
36	Provider Participation Fee	167,899	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,987,226	40
41	Income before Income Taxes (line 30 minus line 40)**	57,001	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 57,001	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,968,465	44
45	Private Pay - Net Inpatient Revenue	331,569	45
46	Medicare - Net Inpatient Revenue	247,735	46
47	Other-(specify) <u>Charity Therapy Allowance</u>	(7,113)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,540,656	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Collinsville Rehab & Hlth CC

0048447

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,080	2,080	\$ 69,020	\$ 33.18	1
2	Assistant Director of Nursing	796	796	21,507	27.02	2
3	Registered Nurses	3,302	3,305	84,309	25.51	3
4	Licensed Practical Nurses	14,278	14,586	291,439	19.98	4
5	CNAs & Orderlies	40,494	41,338	431,218	10.43	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,694	1,810	21,921	12.11	9
10	Activity Assistants					10
11	Social Service Workers	2,080	2,080	34,380	16.53	11
12	Dietician					12
13	Food Service Supervisor	1,852	1,852	25,727	13.89	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,712	9,990	87,256	8.73	15
16	Dishwashers					16
17	Maintenance Workers	1,979	2,084	35,455	17.01	17
18	Housekeepers	8,222	8,546	84,483	9.89	18
19	Laundry	6,334	6,664	57,556	8.64	19
20	Administrator	2,080	2,080	67,800	32.60	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,966	1,990	27,450	13.79	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: CPC	2,080	2,080	54,356	26.13	32
33	Other(specify) <u>Transportation</u>	1,370	1,370	13,759	10.04	33
34	TOTAL (lines 1 - 33)	100,319	102,651	\$ 1,407,636 *	\$ 13.71	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	20	\$ 1,006	L1, C3	35
36	Medical Director	Monthly	13,200	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,038	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	4	220	L10, C3	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)	24	\$ 18,464		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Tara Holmes	Administrator	0	\$ 67,800	Workers' Compensation Insurance	\$ 55,993	IDPH License Fee	\$ 3,980	
				Unemployment Compensation Insurance	51,801	Advertising: Employee Recruitment	(833)	
				FICA Taxes	101,356	Health Care Worker Background Check		
				Employee Health Insurance	(9,320)	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks	135 1,351	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	0	
				Employee Relations	4,774	Miscellaneous Dues & Subscriptions	375	
				Employee Retirement	293	Home Office Allocation	3,368	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 67,800	TOTAL (agree to Schedule V, line 22, col.8)		\$ 8,241		
B. Administrative - Other							Less: Public Relations Expense ()	
Description			Amount				Non-allowable advertising ()	
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 145,100				Yellow page advertising ()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 145,100	TOTAL (agree to Schedule V, line 22, col.8)			\$ 204,897	
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
Miles Reporting Company	Transcription Fees		\$ 536				Out-of-State Travel	\$
Odessian, LLC	Computer Services		150					
Charter Communications	Computer Services		864				In-State Travel	
Brown & James	Legal Services		14,123	N/A				
Sorling, Northrup, Hanna	Legal Services		4,319				Seminar Expense	
Honkamp Krueger & Co.	Accounting Fees		6,363				Home Office Allocation	4
Dorothy Ley & Reel Law	Legal Fees		50,000					
Vicki Champion	Legal Fees		4,500				Entertainment Expense ()	
U.S. Legal Support	Court Reporting Fees		583				TOTAL (agree to Sch. V, line 24, col. 8)	\$ 4
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 81,438	TOTAL		\$		

* Attach copy of IMRF notifications

**See instructions.

Collinsville Rehab & Hlth CC
0048447
Period Beginning
Period End

1/1/2013
12/31/2013

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		81,438
Home Office Allocation		
SmithAmundsen	Legal	506
Cole, Schotz, Meisel	Legal	278
Black, Hedin, Ballard	Legal	25
Ginoli & Company	Accountants	5,213
Allpayer Exchange	Computer Services	320
Miscellaneous	Computer Services	76
Odessian LLC	Computer Services	40
CCH	Computer Services	12
Lexis-Nexis	Computer Services	5
Ipanema Solutions	Computer Services	11
Macquarie Technology Services	Computer Services	72
Advanced Answers on Demand	Computer Services	3743
TeamViewer	Computer Services	12
Stratus Networks	Computer Services	302
Kemper Technology	Computer Services	233
AT&T	Computer Services	4
Medifax	Computer Services	34
Vision Share/Ability Network	Computer Services	513
Barracuda	Computer Services	92
CIAN	Computer Services	123
Comcast	Computer Services	27
Emdeon	Computer Services	41
Marotta Gund Budd & Dzera	Other Prof Fees	1146
David Budde	Other Prof Fees	24
Pharmacy Price Mangement	Other Prof Fees	95

All Scripts	Other Prof Fees	169
U.S. Bank	Other Prof Fees	2,310
Total (agree to Schedule V, line 19, column 8)		<u>96,864</u>

**Collinsville Rehab & Hlth CC
0048447**

**Period Beginning 1/1/2013
Period End 12/31/2013**

Schedule 21B

XIX. SUPPORT SCHEDULE

Legal Fees

Facility

Vendor/Payee	Invoice Total	Allocation %	Total
Brown and James	3,212.78	100%	3,213
Brown and James	4,049.26	100%	4,049
Sorling Northrup Attorneys	105.00	100%	105
Brown and James	2,651.59	100%	2,652
Dorothy Ley and Reel Law Firm	50,000.00	100%	50,000
Sorling Northrup Attorneys	861.00	100%	861
Sorling Northrup Attorneys	84.00	100%	84
Brown and James	324.82	100%	325
Brown and James	582.50	100%	583
U.S. Legal Support	3,655.76	100%	3,656
Sorling Northrup Attorneys	462.00	100%	462
Brown and James	600.00	100%	600
Sorling Northrup Attorneys	938.00	100%	938
Sorling Northrup Attorneys	546.00	100%	546
Vickie L. Champion	4,500.00	100%	4,500
Sorling Northrup Attorneys	777.00	100%	777
Sorling Northrup Attorneys	84.00	100%	84
Brown and James	91.35	100%	91

Home Office Allocation

Smith Amundsen	38,549.00	1.31%	506
Cole, Schotz, Meisel	21,229.00	1.31%	278
Black, Hedin, Ballard	1,999.00	1.31%	25

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Total Legal Fees

74,334

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

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

Facility Name & ID Number Collinsville Rehab & Hlth CC

0048447

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 19,318 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. \$ 167,899
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,815
- (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. \$ 12,054
- 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? Yes
Attach invoices and a summary of services for all architect and appraisal fees.