

Facility Name & ID Number Decatur Rehab & Hlth Care Ct

0047449 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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	58	Intermediate (ICF)	58	21,170	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	58	TOTALS	58	21,170	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					8
9	SNF/PED					9
10	ICF	13,265	963	636	14,864	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,265	963	636	14,864	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.21%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 10/1/2005

J. Was the facility purchased or leased after January 1, 1978?
YES Date 10/1/2005 NO

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number

Decatur Rehab & Hlth Care Ct

0047449

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

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	115,721	7,792		123,513		123,513	2,929	126,442		1
2	Food Purchase		85,002		85,002		85,002	(1,791)	83,211		2
3	Housekeeping	115,992	22,823		138,815		138,815	29	138,844		3
4	Laundry	148	18,135		18,283		18,283		18,283		4
5	Heat and Other Utilities			35,352	35,352		35,352	222	35,574		5
6	Maintenance	30,521	11,169	22,116	63,806		63,806	1,435	65,241		6
7	Other (specify):* Home Off. Ben. All.							166	166		7
8	TOTAL General Services	262,382	144,921	57,468	464,771		464,771	2,990	467,761		8
	B. Health Care and Programs										
9	Medical Director			15,000	15,000		15,000		15,000		9
10	Nursing and Medical Records	595,998	49,857	4,659	650,514		650,514	10	650,524		10
10a	Therapy										10a
11	Activities	25,060	242	759	26,061		26,061	(2,474)	23,587		11
12	Social Services	26,611			26,611		26,611		26,611		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.										15
16	TOTAL Health Care and Programs	647,669	50,099	20,418	718,186		718,186	(2,464)	715,722		16
	C. General Administration										
17	Administrative			162,600	162,600		162,600	(99,264)	63,336		17
18	Directors Fees										18
19	Professional Services			8,655	8,655		8,655	77,728	86,383		19
20	Dues, Fees, Subscriptions & Promotions			5,798	5,798		5,798	1,010	6,808		20
21	Clerical & General Office Expenses	23,979	1,509	25,118	50,606		50,606	38,770	89,376		21
22	Employee Benefits & Payroll Taxes			161,860	161,860		161,860	(17)	161,843		22
23	Inservice Training & Education							59	59		23
24	Travel and Seminar							3	3		24
25	Other Admin. Staff Transportation			8,449	8,449		8,449	2,711	11,160		25
26	Insurance-Prop.Liab.Malpractice			21,738	21,738		21,738	524	22,262		26
27	Other (specify):* Home Off. Ben. All.							3,360	3,360		27
28	TOTAL General Administration	23,979	1,509	394,218	419,706		419,706	24,884	444,590		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	934,030	196,529	472,104	1,602,663		1,602,663	25,410	1,628,073		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

Decatur Rehab & Hlth Care Ct

#0047449

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			20,878	20,878	20,878	2,057	22,935				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			8,752	8,752	8,752	23,826	32,578				32
33	Real Estate Taxes			23,472	23,472	23,472	236	23,708				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			21,328	21,328	21,328	434	21,762				35
36	Other (specify):*											36
37	TOTAL Ownership			74,430	74,430	74,430	26,553	100,983				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		15,249		15,249	15,249		15,249				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			121,342	121,342	121,342		121,342				42
43	Other (specify):* Non-allowable Costs		451	45,241	45,692	45,692	(45,692)					43
44	TOTAL Special Cost Centers		15,700	166,583	182,283	182,283	(45,692)	136,591				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	934,030	212,229	713,117	1,859,376	1,859,376	6,271	1,865,647				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	(1,854)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(513)	30		9
10	Interest and Other Investment Income	(6,025)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(86)	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	(17,866)	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	(24,838)	43		24
25	Fund Raising, Advertising and Promotional	(1,833)	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	(3,856)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (56,871)		\$	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)	63,142	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 63,142		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 6,271		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

Decatur Rehab & Hlth Care Ct

ID# 0047449

Report Period Beginning: 1/1/2013

Ending: 12/31/2013

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Offset Transportation Revenue	(2,474)	11	1
2	Disallowed Special Events	68	43	2
3	Offset Miscellaneous Office Supplies Revenue	(313)	21	3
4	Labs Part A	(178)	43	4
5	Disallowed Travel Air	(959)	43	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		(3,856)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Decatur Rehab & Hlth Care Ct# 0047449

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 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	2,929	0	0	0	0	0	0	0	0	0	2,929	1
2	Food Purchase	(1,854)	63	0	0	0	0	0	0	0	0	0	(1,791)	2
3	Housekeeping	0	29	0	0	0	0	0	0	0	0	0	29	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	222	0	0	0	0	0	0	0	0	0	222	5
6	Maintenance	0	1,435	0	0	0	0	0	0	0	0	0	1,435	6
7	Other (specify):*	0	166	0	0	0	0	0	0	0	0	0	166	7
8	TOTAL General Services	(1,854)	4,844	0	0	0	0	0	0	0	0	0	2,990	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	10	0	0	0	0	0	0	0	0	0	10	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(2,474)	0	0	0	0	0	0	0	0	0	0	(2,474)	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	(2,474)	10	0	0	0	0	0	0	0	0	0	(2,464)	16
	C. General Administration													
17	Administrative	0	(99,264)	0	0	0	0	0	0	0	0	0	(99,264)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	6,175	0	71,553	0	0	0	0	0	0	0	77,728	19
20	Fees, Subscriptions & Promotions	0	0	393	617	0	0	0	0	0	0	0	1,010	20
21	Clerical & General Office Expenses	(313)	0	36,299	2,784	0	0	0	0	0	0	0	38,770	21
22	Employee Benefits & Payroll Taxes	0	0	0	(17)	0	0	0	0	0	0	0	(17)	22
23	Inservice Training & Education	0	0	59	0	0	0	0	0	0	0	0	59	23
24	Travel and Seminar	0	0	3	0	0	0	0	0	0	0	0	3	24
25	Other Admin. Staff Transportation	0	0	2,711	0	0	0	0	0	0	0	0	2,711	25
26	Insurance-Prop.Liab.Malpractice	0	0	524	0	0	0	0	0	0	0	0	524	26
27	Other (specify):*	0	0	3,360	0	0	0	0	0	0	0	0	3,360	27
28	TOTAL General Administration	(313)	(93,089)	43,349	74,937	0	24,884	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(4,641)	(88,235)	43,349	74,937	0	25,410	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Decatur Rehab & Hlth Care Ct# 0047449

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	(513)	0	2,406	164	0	0	0	0	0	0	0	2,057	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,025)	0	4,003	25,848	0	0	0	0	0	0	0	23,826	32
33	Real Estate Taxes	0	0	236	0	0	0	0	0	0	0	0	236	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	434	0	0	0	0	0	0	0	0	434	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(6,538)	0	7,079	26,012	0	26,553	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):*	(45,692)	0	0	0	0	0	0	0	0	0	0	(45,692)	43
44	TOTAL Special Cost Centers	(45,692)	0	0	0	0	0	0	0	0	0	0	(45,692)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(56,871)	(88,235)	50,428	100,949	0	0	0	0	0	0	0	6,271	45

VII. RELATED PARTIES

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

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

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 2,929	\$ 2,929	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	63	63	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	29	29	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	222	222	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	1,435	1,435	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	166	166	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	10	10	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	162,600	Petersen Health Care, Inc.	100.00%	63,336	(99,264)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	6,175	6,175	12
13	V							13
14	Total		\$ 162,600			\$ 74,365	\$ * (88,235)	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%	\$ 393	\$	393	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	36,299		36,299	16
17	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	59		59	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	3		3	18
19	V	25 Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	2,711		2,711	19
20	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	524		524	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	3,360		3,360	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	2,406		2,406	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	4,003		4,003	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	236		236	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%	434		434	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		\$			\$ 50,428	\$ *	50,428	39

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

Facility Name & ID Number

Decatur Rehab & Hlth Care Ct

0047449

Report Period Beginning:

1/1/2013

Ending:

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	\$	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%	71,553	71,553	25
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Operations, LLC	100.00%	617	617	26
27	V	21 Clerical and General Office		Petersen Health Operations, LLC	100.00%	2,784	2,784	27
28	V	22 Employee Benefits & Payroll		Petersen Health Operations, LLC	100.00%	(17)	(17)	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%	0		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%	164	164	34
35	V	32 Interest		Petersen Health Operations, LLC	100.00%	25,848	25,848	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%	0		38
39	Total		\$			\$ 100,949	\$ * 100,949	39

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

Facility Name & ID Number

Decatur Rehab & Hlth Care Ct

0047449

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

Decatur Rehab & Hlth Care Ct

0047449

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

Decatur Rehab & Hlth Care Ct

0047449

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

Decatur Rehab & Hlth Care Ct

0047449

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 Decatur Rehab & Hlth Care Ct # 0047449 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 Decatur Rehab & Hlth Care Ct

0047449

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	14,864	\$ 2,929	1
2	2	Food	Resident Days	1,560,986	75	6,577	0	14,864	63	2
3	3	Housekeeping	Resident Days	1,560,986	75	3,057	0	14,864	29	3
4	4	Laundry	Resident Days	1,560,986	75	0	0	14,864	0	4
5	5	Utilities	Resident Days	1,560,986	75	23,338	0	14,864	222	5
6	6	Maintenance	Resident Days	1,560,986	75	150,672	97,358	14,864	1,435	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,560,986	75	17,394	0	14,864	166	7
8	10	Nursing and Medical Records	Resident Days	1,560,986	75	1,082	0	14,864	10	8
9	10A	Therapy	Resident Days	1,560,986	75	0	0	14,864	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,560,986	75	0	0	14,864	0	10
11	17	Administrative	Resident Days	1,560,986	75	4,578,456	4,578,456	14,864	63,336	11
12	19	Professional Services	Resident Days	1,560,986	75	648,504	0	14,864	6,175	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,560,986	75	41,231	0	14,864	393	13
14	21	Clerical and General Office	Resident Days	1,560,986	75	3,812,055	3,383,297	14,864	36,299	14
15	23	Inservice Training & Education	Resident Days	1,560,986	75	6,148	0	14,864	59	15
16	24	Travel and Seminar	Resident Days	1,560,986	75	313	0	14,864	3	16
17	25	Other Admin. Staff Transport.	Resident Days	1,560,986	75	284,745	0	14,864	2,711	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,560,986	75	54,993	0	14,864	524	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,560,986	75	352,851	0	14,864	3,360	19
20	30	Depreciation	Resident Days	1,560,986	75	252,711	0	14,864	2,406	20
21	32	Interest	Resident Days	1,560,986	75	420,365	0	14,864	4,003	21
22	33	Real Estate Taxes	Resident Days	1,560,986	75	24,742	0	14,864	236	22
23	34	Rent-Facility and Grounds	Resident Days	1,560,986	75	0	0	14,864	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,560,986	75	45,546	0	14,864	434	24
25	TOTALS					\$ 11,032,372	\$ 8,354,323		\$ 124,793	25

Facility Name & ID Number Decatur Rehab & Hlth Care Ct

0047449

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 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	408,598	21	\$	14,864	\$	1
2	2	Food	Resident Days	408,598	21		14,864		2
3	3	Housekeeping	Resident Days	408,598	21		14,864		3
4	4	Laundry	Resident Days	408,598	21		14,864		4
5	5	Utilities	Resident Days	408,598	21		14,864		5
6	6	Maintenance	Resident Days	408,598	21		14,864		6
7	7	Mgmt. Allocation of Benefits	Resident Days	408,598	21		14,864		7
8	10	Nursing and Medical Records	Resident Days	408,598	21		14,864		8
9	12	Social Services	Resident Days	408,598	21		14,864		9
10	17	Administrative	Resident Days	408,598	21		14,864		10
11	19	Professional Services	Resident Days	408,598	21	1,966,927	14,864	71,553	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	408,598	21	16,972	14,864	617	12
13	21	Clerical and General Office	Resident Days	408,598	21	76,520	14,864	2,784	13
14	22	Employee Benefits & Payroll	Resident Days	408,598	21	(465)	14,864	(17)	14
15	23	Inservice Training & Education	Resident Days	408,598	21		14,864		15
16	24	Travel and Seminar	Resident Days	408,598	21		14,864		16
17	25	Other Admin. Staff Transport.	Resident Days	408,598	21		14,864		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	408,598	21		14,864		18
19	27	Mgmt. Allocation of Benefits	Resident Days	408,598	21		14,864		19
20	30	Depreciation	Resident Days	408,598	21	4,500	14,864	164	20
21	32	Interest	Resident Days	408,598	21	710,525	14,864	25,848	21
22	33	Real Estate Taxes	Resident Days	408,598	21		14,864		22
23	34	Rent-Facility and Grounds	Resident Days	408,598	21		14,864		23
24	35	Rent-Equipment & Vehicles	Resident Days	408,598	21		14,864		24
25	TOTALS					\$ 2,774,979	\$	\$ 100,949	25

Facility Name & ID Number

Decatur Rehab & Hlth Care Ct

0047449

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						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
A. Directly Facility Related																	
Long-Term																	
1	Bank of America		X	Mortgage	Varies	1/19/2007	\$ 325,000	\$ 242,533	12/31/13	Varies	\$ 8,752						
2																	
3																	
4																	
5																	
Working Capital																	
6																	
7																	
8																	
9	TOTAL Facility Related						\$ 325,000	\$ 242,533			\$ 8,752						
B. Non-Facility Related*																	
10																	
11											(6,025)						
12											4,003						
13											25,848						
14	TOTAL Non-Facility Related						\$	\$			\$ 23,826						
15	TOTALS (line 9+line14)						\$ 325,000	\$ 242,533			\$ 32,578						

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.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1. Real Estate Tax accrual used on 2012 report.				\$	24,108	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.)		2012		\$	23,436	2
3. Under or (over) accrual (line 2 minus line 1).				\$	(672)	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	24,144	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.						
					236	
					Home Office Allocation	
TOTAL REFUND	\$	For	Tax Year.			
				\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	23,708	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2008	23,281	8			
	2009	23,736	9			
	2010	23,810	10			
	2011	23,400	11			
	2012	23,436	12			
Accrual based on prior year tax bill.						
				FOR BHF USE ONLY		
				13	FROM R. E. TAX STATEMENT FOR 2012 \$	13
				14	PLUS APPEAL COST FROM LINE 5 \$	14
				15	LESS REFUND FROM LINE 6 \$	15
				16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES 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: 8,653 B. General Construction Type: Exterior Brick Frame Concrete 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>43,560</u>	<u>2005</u>	<u>\$ 37,500</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	43,560		\$ 37,500	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	58	2005	1970	\$ 275,500	\$	25	\$ 11,020	\$ 11,020	\$ 93,670	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Original Land Improvements	2005		10,000		15	667	667	5,669	9
10	Sidewalks	2006		2,311		15	154	154	1,155	10
11	Remodel Nurses Station	2007		6,718		15	448	448	2,912	11
12	Water Heater-100 Gallon	2008		5,604		5	564	564	5,604	12
13	Painting-Exterior	2009		4,908		15	328	328	1,712	13
14	Sprinkler System Installation	2009		11,774		15	785	785	3,532	14
15	Windows Installation-(41)	2009		11,234		15	749	749	3,370	15
16	Dry Pendant Installation	2010		6,270		15	418	418	1,463	16
17	Sidewalk Replacement	2011		2,850		15	190	190	475	17
18	Roofing-Flat Section of Building	2013		10,400		15	347	347	347	18
19	Parking Lot-Asphalt	2013		23,468		25	469	469	469	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				1,011			(1,011)		30
31	Building Booked				11,069			(11,069)		31
32	Building Improvement Booked				3,748			(3,748)		32
33										33
34	2013-Home Office Allocation-Building Improvements			6,989			168	168		34
35	2013-Home Office Allocation-Land Improvements			652			42	42		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				
40								40				
41								41				
42								42				
43								43				
44								44				
45								45				
46								46				
47								47				
48								48				
49								49				
50								50				
51								51				
52								52				
53								53				
54								54				
55								55				
56								56				
57								57				
58								58				
59								59				
60								60				
61								61				
62								62				
63								63				
64								64				
65								65				
66								66				
67								67				
68								68				
69								69				
70	TOTAL (lines 4 thru 69)	\$	378,678	\$	15,828	\$	16,349	\$	521	\$	120,378	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	\$ 38,712	\$ 4,882	\$ 3,872	\$ (1,010)	5-10 yrs.	\$ 22,857	71
72	Current Year Purchases	7,073	168	354	186	10 yrs.	354	72
73	Fully Depreciated Assets	62,280					62,280	73
74	Home Office Allocation			2,360	2,360			74
75	TOTALS	\$ 108,065	\$ 5,050	\$ 6,586	\$ 1,536		\$ 85,491	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)	\$ 524,243	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 20,878	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 22,935	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,057	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 205,869	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	Vacant Land	\$ 75,000	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 75,000	\$	\$	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 Decatur Rehab & Hlth Care Ct

0047449

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: \$ 12,098 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	2012 Ford E250	\$ 828.41	\$ 9,664	17
18					18
19					19
20					20
21	TOTAL		\$ 828.41	\$ 9,664	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.

**Decatur Rehab & Hlth Care Ct
0047449**

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	\$ 5,908
Dishwasher	713
Laundry Equipment	-
Copier	5,043
Home Office Allocation	434
	<u>12,098</u>

Facility Name & ID Number Decatur Rehab & Hlth Care Ct # 0047449 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? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Pharmacy Veterans	39(2)					15,249		15,249	12
13	Other (specify):									13
14	TOTAL			\$		\$	15,249		\$ 15,249	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 Decatur Rehab & Hlth Care Ct# 0047449Report 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	\$ 468,738	\$ 468,738	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>41,004</u>)	295,731	295,731	3
4	Supply Inventory (priced at)	7,380	7,380	4
5	Short-Term Investments			5
6	Prepaid Insurance	20,523	20,523	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Security Deposit & PPD Lease</u>	6,463	6,463	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 798,835	\$ 798,835	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	127,661	37,500	13
14	Buildings, at Historical Cost	275,500	282,489	14
15	Leasehold Improvements, at Historical Cost	80,376	96,189	15
16	Equipment, at Historical Cost	108,066	108,065	16
17	Accumulated Depreciation (book methods)	(208,427)	(205,869)	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): <u>Non-Care Land</u>		75,000	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 383,176	\$ 393,374	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,182,011	\$ 1,192,209	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 258,864	\$ 258,864	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	15,938	15,938	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,506	5,506	31
32	Accrued Real Estate Taxes(Sch.IX-B)	24,144	24,144	32
33	Accrued Interest Payable	662	662	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	29,793	29,793	36
37	<u>Accrued Management Fees</u>	153,277	153,277	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 488,184	\$ 488,184	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	242,533	242,533	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	<u>Due to Due From</u>	542,601	542,601	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 785,134	\$ 785,134	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,273,318	\$ 1,273,318	46
47	TOTAL EQUITY(page 18, line 24)	\$ (91,307)	\$ (81,109)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,182,011	\$ 1,192,209	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 127,923	1
2	Restatements (describe):		2
3	Rounding	2	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 127,925	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(219,232)	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)	\$ (219,232)	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)	\$ (91,307)	24 *

* This must agree with page 17, line 47.

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

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 1,629,478	1
2	Discounts and Allowances for all Levels	(12,380)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,617,098	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,854	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	12,380	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 14,234	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	6,025	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 6,025	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	313	28
28a	Transportation Revenue	2,474	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,787	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,640,144	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	464,771	31
32	Health Care	718,186	32
33	General Administration	419,706	33
B. Capital Expense			
34	Ownership	74,430	34
C. Ancillary Expense			
35	Special Cost Centers	60,941	35
36	Provider Participation Fee	121,342	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,859,376	40
41	Income before Income Taxes (line 30 minus line 40)**	(219,232)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (219,232)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,421,758	44
45	Private Pay - Net Inpatient Revenue	134,712	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) <u>Veterans -Net Patient Revenue</u>	60,628	47
48	Other-(specify) <u>Charity and Insurance Contractual Allowance</u>		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 1,617,098	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 Decatur Rehab & Hlth Care Ct

0047449

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	1,876	1,964	\$ 61,111	\$ 31.12	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,534	2,576	76,461	29.68	3
4	Licensed Practical Nurses	6,240	6,429	130,593	20.31	4
5	CNAs & Orderlies	29,468	30,185	296,993	9.84	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,953	1,981	25,060	12.65	9
10	Activity Assistants					10
11	Social Service Workers	1,738	1,836	26,611	14.49	11
12	Dietician					12
13	Food Service Supervisor	1,898	2,026	28,638	14.14	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,335	9,875	87,083	8.82	15
16	Dishwashers					16
17	Maintenance Workers	1,851	2,032	30,521	15.02	17
18	Housekeepers	11,308	11,881	115,992	9.76	18
19	Laundry	15	15	148	9.87	19
20	Administrator	2,080	2,080	63,336	30.45	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,825	1,854	23,979	12.93	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>CPC</u>	1,934	2,116	30,840	14.57	33
34	TOTAL (lines 1 - 33)	74,055	76,850	\$ 997,366 *	\$ 12.98	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant			35	
36	Medical Director	Monthly	15,000	L9, C3	36
37	Medical Records Consultant	4	100	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,977	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)	4	\$ 18,077		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	73	1,582	L10, C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	73	\$ 1,582		53

Decatur Rehab & Hlth Care Ct
0047449

Period Beginning

1/1/2013

Period End

12/31/2013

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		8,655
Home Office Allocation		
SmithAmundsen	Legal	367
Cole, Schotz, Meisel	Legal	202
Black, Hedin, Ballard	Legal	18
Elias, Meginnes, Riffle & Seghetti	Legal	37
Miller, Hall, and Triggs	Legal	772
Evapar	Legal	149
Ginoli & Company	Accountants	2125
E-Health Data Solutions	Computer Services	2643
Miscellaneous	Computer Services	58
Odessian LLC	Computer Services	29
CCH	Computer Services	8
Lexis-Nexis	Computer Services	3
Ipanema Solutions	Computer Services	8
Macquarie Technology Services	Computer Services	52
Advanced Answers on Demand	Computer Services	2718
TeamViewer	Computer Services	9
Stratus Networks	Computer Services	219
Kemper Technology	Computer Services	169
AT&T	Computer Services	3
Medifax	Computer Services	25
Vision Share/Ability Network	Computer Services	372
Barracuda	Computer Services	67
CIAN	Computer Services	89
Comcast	Computer Services	20
Emdeon	Computer Services	30

Marotta Gund Budd & Dzera	Other Prof Fees	66349
David Budde	Other Prof Fees	17
Pharmacy Price Mangement	Other Prof Fees	343
All Scripts	Other Prof Fees	609
Registered Agent Solutions	Other Prof Fees	29
Healthink	Other Prof Fees	189
Total (agree to Schedule V, line 19, column 8)		<u>86,383</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												
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Facility Name & ID Number Decatur Rehab & Hlth Care Ct

0047449

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. \$ 13,746 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. \$ 121,342
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. \$ 1,854
- (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. \$ 2,474
- 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.