

		FOR BHF USE					

LL1

DEPARTMENT OF
FINANCE

I. IDPH License ID Number: 0047498

Facility Name: McLeansboro Rehab & HCC

Address: 405 West Carpenter McLeansboro
Number City

County: Hamilton

Telephone Number: (618) 643-3728 Fax # (618) 643-2330

HFS ID Number: _____

Date of Initial License for Current Owners: 10/1/2005

Type of Ownership:

<input type="checkbox"/>	VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/>	PROPRIETARY	<input type="checkbox"/>	GOV
<input type="checkbox"/>	Charitable Corp.	<input type="checkbox"/>	Individual	<input type="checkbox"/>	
<input type="checkbox"/>	Trust	<input type="checkbox"/>	Partnership	<input type="checkbox"/>	
IRS Exemption Code	_____	<input type="checkbox"/>	Corporation	<input type="checkbox"/>	
		<input checked="" type="checkbox"/>	"Sub-S" Corp.	<input type="checkbox"/>	
		<input type="checkbox"/>	Limited Liability Co.	<input type="checkbox"/>	
		<input type="checkbox"/>	Trust	<input type="checkbox"/>	
		<input type="checkbox"/>	Other	<input type="checkbox"/>	

In the event there are further questions about this report, please contact:
 Name: Mike Kocher Telephone Number: (309) 689-5850
 Email Address: _____

2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
ANNUAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATE'S PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENT. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGER.

<p>_____</p> <p><u>62859</u></p> <p>Zip Code</p>	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2013</u> to _____ and certify to the best of my knowledge and belief that the said data are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p>
<p>_____</p> <p>Zip Code</p>	<p>(Signed) _____</p> <p>(Type or Print Name) <u>Mark B. Petersen</u></p> <p>(Title) <u>Chief Executive Officer</u></p>
<p>_____</p> <p>Zip Code</p>	<p>(Signed) _____</p> <p>(Print Name and Title) _____</p> <p>(Firm Name & Address) _____</p> <p>(Telephone) (____) _____ Fax # _____</p>
<p>_____</p> <p>Zip Code</p>	<p>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001</p> <p align="right">Phon _____</p>

Zip Code

Zip Code

Zip Code

Facility Name & ID Number McLeansboro Rehab & HCC

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	43	Skilled (SNF)	43	15,695
2		Skilled Pediatric (SNF/PED)		
3		Intermediate (ICF)		
4		Intermediate/DD		
5		Sheltered Care (SC)		
6		ICF/DD 16 or Less		
7	43	TOTALS	43	15,695

B. Census-For the entire report period.

	1	2 3 4 5			
	Level of Care	Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	Total
8	SNF	4,887	1,953	917	7,757
9	SNF/PED				
10	ICF				
11	ICF/DD				
12	SC				
13	DD 16 OR LESS				
14	TOTALS	4,887	1,953	917	7,757

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

49.42%

0047498 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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 [X] NO []

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

YES [] NO [X]

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 [X] Date 10/1/2005 NO []

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

YES [X] NO [] If YES, enter number of beds certified 43 and days of care provided 826

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [] CASH* []

Is your fiscal year identical to your tax year? YES [X] NO []

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

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

Table with 2 columns: Line number (1-7) and empty space for notes.

Table with 2 columns: Line number (8-14) and empty space for notes.

Facility Name & ID Number

McLeansboro Rehab & HCC

#

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

	Operating Expenses	Costs Per General Ledger			Total
		Salary/Wage 1	Supplies 2	Other 3	
	A. General Services				
1	Dietary	86,131	3,981	2,313	92,425
2	Food Purchase		55,259		55,259
3	Housekeeping	36,464	9,903		46,367
4	Laundry	15,952	5,058		21,010
5	Heat and Other Utilities			49,777	49,777
6	Maintenance	29,770	13,384	9,993	53,147
7	Other (specify):* Home Off. Ben. All.				
8	TOTAL General Services	168,317	87,585	62,083	317,985
	B. Health Care and Programs				
9	Medical Director			7,800	7,800
10	Nursing and Medical Records	426,391	31,252	3,946	461,589
10a	Therapy			82,167	82,167
11	Activities	21,563	47	2,311	23,921
12	Social Services	29,388	3		29,391
13	CNA Training				
14	Program Transportation				
15	Other (specify):* Home Off. Ben. All.				
16	TOTAL Health Care and Programs	477,342	31,302	96,224	604,868
	C. General Administration				
17	Administrative			121,000	121,000
18	Directors Fees				
19	Professional Services			7,833	7,833
20	Dues, Fees, Subscriptions & Promotions			4,909	4,909
21	Clerical & General Office Expenses	26,580	2,145	34,278	63,003
22	Employee Benefits & Payroll Taxes			109,747	109,747
23	Inservice Training & Education				
24	Travel and Seminar				
25	Other Admin. Staff Transportation			8,106	8,106
26	Insurance-Prop.Liab.Malpractice			16,380	16,380
27	Other (specify):* Home Off. Ben. All.				
28	TOTAL General Administration	26,580	2,145	302,253	330,978
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	672,239	121,032	460,560	1,253,831

*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

Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
				9	10	
	92,425	1,529	93,954			1
	55,259	(892)	54,367			2
	46,367	15	46,382			3
	21,010		21,010			4
	49,777	116	49,893			5
	53,147	749	53,896			6
		86	86			7
	317,985	1,603	319,588			8
	7,800		7,800			9
	461,589	5	461,594			10
	82,167		82,167			10a
	23,921	(2,877)	21,044			11
	29,391		29,391			12
						13
						14
						15
	604,868	(2,872)	601,996			16
	121,000	(72,153)	48,847			17
						18
	7,833	40,564	48,397			19
	4,909	527	5,436			20
	63,003	20,338	83,341			21
	109,747	(9)	109,738			22
		31	31			23
		2	2			24
	8,106	1,415	9,521			25
	16,380	273	16,653			26
		1,753	1,753			27
	330,978	(7,259)	323,719			28
	1,253,831	(8,528)	1,245,303			29

e a detailed explanation of each reclassification.

Facility Name & ID Number McLeansboro Rehab & HCC

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger			
		Salary/Wage 1	Supplies 2	Other 3	Total 4
	D. Ownership				
30	Depreciation			38,143	38,143
31	Amortization of Pre-Op. & Org.				
32	Interest			17,501	17,501
33	Real Estate Taxes			6,933	6,933
34	Rent-Facility & Grounds				
35	Rent-Equipment & Vehicles			19,872	19,872
36	Other (specify):*				
37	TOTAL Ownership			82,449	82,449
	Ancillary Expense				
	E. Special Cost Centers				
38	Medically Necessary Transportation				
39	Ancillary Service Centers		27,786		27,786
40	Barber and Beauty Shops				
41	Coffee and Gift Shops				
42	Provider Participation Fee			64,437	64,437
43	Other (specify):* Non-allowable Costs		1,298	40,433	41,731
44	TOTAL Special Cost Centers		29,084	104,870	133,954
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	672,239	150,116	647,879	1,470,234

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$100

Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
				9	10	
	38,143	3,231	41,374			30
						31
	17,501	9,556	27,057			32
	6,933	123	7,056			33
						34
	19,872	226	20,098			35
						36
	82,449	13,136	95,585			37
						38
	27,786		27,786			39
						40
						41
	64,437		64,437			42
	41,731	(41,731)				43
	133,954	(41,731)	92,223			44
	1,470,234	(37,123)	1,433,111			45

0.

VI. ADJUSTMENT DETAIL

**A. The expenses indicated below are non-allowable and should
In column 2 below, reference the line on which the particula**

		1	2	3
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY
1	Day Care	\$		\$
2	Other Care for Outpatients			
3	Governmental Sponsored Special Programs			
4	Non-Patient Meals	(925)	2	
5	Telephone, TV & Radio in Resident Rooms	(2,978)	43	
6	Rented Facility Space			
7	Sale of Supplies to Non-Patients			
8	Laundry for Non-Patients			
9	Non-Straightline Depreciation	1,890	30	
10	Interest and Other Investment Income	(6,022)	32	
11	Discounts, Allowances, Rebates & Refunds			
12	Non-Working Officer's or Owner's Salary			
13	Sales Tax	(46)	43	
14	Non-Care Related Interest			
15	Non-Care Related Owner's Transactions			
16	Personal Expenses (Including Transportation)			
17	Non-Care Related Fees			
18	Fines and Penalties	(4,971)	43	
19	Entertainment			
20	Contributions	(500)	43	
21	Owner or Key-Man Insurance			
22	Special Legal Fees & Legal Retainers			
23	Malpractice Insurance for Individuals			
24	Bad Debt	(19,387)	43	
25	Fund Raising, Advertising and Promotional	(3,083)	43	
26	Income Taxes and Illinois Personal Property Replacement Tax			
27	CNA Training for Non-Employees			
28	Yellow Page Advertising			
29	Other-Attach Schedule <u>See Page 5A</u>	(13,701)	Various	
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (49,723)		\$

BHF USE ONLY							
48		49		50		51	

be adjusted out of Schedule V, pages 3 or 4 via column 7.
 r cost was included. (See instructions.)

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

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		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)	12,600	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 12,600		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (37,123)		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

McLeansboro Rehab & HCC

ID# 0047498
 Report Period Beginning: 1/1/2013
 Ending: 12/31/2013

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (6,940)	43	1
2	X-Rays-Part A	(2,835)	43	2
3	Resident Flowers	(228)	43	3
4	Offset Miscellaneous Office Supplies Revenue	(58)	21	4
5	Disallowed Air Travel Expense	(959)	20	5
6	Disallowed Special Events	196	43	6
7	Offset Transportation Revenue	(2,877)	11	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
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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	(13,701)		49

Facility Name & ID Number McLeansboro Rehab & HCC

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE
	A. General Services	5 & 5A	6	6A	6B
1	Dietary	0	1,529	0	0
2	Food Purchase	(925)	33	0	0
3	Housekeeping	0	15	0	0
4	Laundry	0	0	0	0
5	Heat and Other Utilities	0	116	0	0
6	Maintenance	0	749	0	0
7	Other (specify):*	0	86	0	0
8	TOTAL General Services	(925)	2,528	0	0
	B. Health Care and Programs				
9	Medical Director	0	0	0	0
10	Nursing and Medical Records	0	5	0	0
10a	Therapy	0	0	0	0
11	Activities	(2,877)	0	0	0
12	Social Services	0	0	0	0
13	CNA Training	0	0	0	0
14	Program Transportation	0	0	0	0
15	Other (specify):*	0	0	0	0
16	TOTAL Health Care and Programs	(2,877)	5	0	0
	C. General Administration				
17	Administrative	0	(72,153)	0	0
18	Directors Fees	0	0	0	0
19	Professional Services	0	3,223	0	37,341
20	Fees, Subscriptions & Promotions	(959)	0	205	322
21	Clerical & General Office Expenses	(58)	0	18,943	1,453
22	Employee Benefits & Payroll Taxes	0	0	0	(9)
23	Inservice Training & Education	0	0	31	0
24	Travel and Seminar	0	0	2	0
25	Other Admin. Staff Transportation	0	0	1,415	0
26	Insurance-Prop.Liab.Malpractice	0	0	273	0
27	Other (specify):*	0	0	1,753	0
28	TOTAL General Administration	(1,017)	(68,930)	22,622	39,107
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(4,819)	(66,397)	22,622	39,107

Summary A
12/31/2013

SUMMARY TOTALS	
(to Sch V, col.7)	
1,529	1
(892)	2
15	3
0	4
116	5
749	6
86	7
1,603	8
0	9
5	10
0	10a
(2,877)	11
0	12
0	13
0	14
0	15
(2,872)	16
(72,153)	17
0	18
40,564	19
(432)	20
20,338	21
(9)	22
31	23
2	24
1,415	25
273	26
1,753	27
(8,218)	28
(9,487)	29

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE
	D. Ownership	5 & 5A	6	6A	6B
30	Depreciation	1,890	0	1,256	85
31	Amortization of Pre-Op. & Org.	0	0	0	0
32	Interest	(6,022)	0	2,089	13,489
33	Real Estate Taxes	0	0	123	0
34	Rent-Facility & Grounds	0	0	0	0
35	Rent-Equipment & Vehicles	0	0	226	0
36	Other (specify):*	0	0	0	0
37	TOTAL Ownership	(4,132)	0	3,694	13,574
	Ancillary Expense				
	E. Special Cost Centers				
38	Medically Necessary Transportation	0	0	0	0
39	Ancillary Service Centers	0	0	0	0
40	Barber and Beauty Shops	0	0	0	0
41	Coffee and Gift Shops	0	0	0	0
42	Provider Participation Fee	0	0	0	0
43	Other (specify):*	(40,772)	0	0	0
44	TOTAL Special Cost Centers	(40,772)	0	0	0
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(49,723)	(66,397)	26,316	52,681

Summary B
12/31/2013

SUMMARY TOTALS (to Sch V, col.7)	
3,231	30
0	31
9,556	32
123	33
0	34
226	35
0	36
13,136	37
0	38
0	39
0	40
0	41
0	42
(40,772)	43
(40,772)	44
(37,123)	45

Facility Name & ID Number McLeansboro Rehab & HCC

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSI
Name	Ownership %	Name
Mark B. Petersen	100	See PG6 - Supp

B. Are any costs included in this report which are a result of transactions with related organizations? management fees, purchase of supplies, and so forth. YES

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Org
Schedule V	Line	Item	Amount	Name of Related O
1	V	1 Dietary	\$	Petersen Health Ca
2	V	2 Food		Petersen Health Ca
3	V	3 Housekeeping		Petersen Health Ca
4	V	4 Laundry		Petersen Health Ca
5	V	5 Utilities		Petersen Health Ca
6	V	6 Maintenance		Petersen Health Ca
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Ca
8	V	10 Nursing and Medical Records		Petersen Health Ca
9	V	10A Therapy		Petersen Health Ca
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Ca
11	V	17 Administrative	121,000	Petersen Health Ca
12	V	19 Professional Services		Petersen Health Ca
13	V			
14	Total		\$ 121,000	

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

See the instructions. Use Page 6-Supplemental as necessary.

OWNING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
	City	Name See PG6 - Supp	City	Type of Business

This includes rent,
NO

accordance with

Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)
Home, Inc.	100.00%	\$ 1,529	\$ 1,529
Home, Inc.	100.00%	33	33
Home, Inc.	100.00%	15	15
Home, Inc.	100.00%	0	
Home, Inc.	100.00%	116	116
Home, Inc.	100.00%	749	749
Home, Inc.	100.00%	86	86
Home, Inc.	100.00%	5	5
Home, Inc.	100.00%	0	
Home, Inc.	100.00%	0	
Home, Inc.	100.00%	48,847	(72,153)
Home, Inc.	100.00%	3,223	3,223
		\$ 54,603	\$ * (66,397)

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Facility Name & ID Number McLeansboro Rehab & HCC

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? If so, list the 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 the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Org
Schedule V		Line	Item	Amount	Name of Related O
15	V	20	Dues, Fees, Subs & Promotions	\$	Petersen Health Care
16	V	21	Clerical and General Office		Petersen Health Care
17	V	23	Inservice Training & Education		Petersen Health Care
18	V	24	Travel and Seminar		Petersen Health Care
19	V	25	Other Admin. Staff Transport.		Petersen Health Care
20	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care
21	V	27	Mgmt. Allocation of Benefits		Petersen Health Care
22	V	30	Depreciation		Petersen Health Care
23	V	32	Interest		Petersen Health Care
24	V	33	Real Estate Taxes		Petersen Health Care
25	V	34	Rent-Facility and Grounds		Petersen Health Care
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care
27	V				
28	V				
29	V				
30	V				
31	V				
32	V				
33	V				
34	V				
35	V				
36	V				
37	V				
38	V				
39	Total			\$	

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

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Facility Name & ID Number McLeansboro Rehab & HCC

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? **1** management fees, purchase of supplies, and so forth. YES

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 Org
Schedule V		Line	Item	Amount	Name of Related O
15	V	1	Dietary	\$	Petersen Health Oper
16	V	2	Food		Petersen Health Oper
17	V	3	Housekeeping		Petersen Health Oper
18	V	4	Laundry		Petersen Health Oper
19	V	5	Utilities		Petersen Health Oper
20	V	6	Maintenance		Petersen Health Oper
21	V	7	Mgmt. Allocation of Benefits		Petersen Health Oper
22	V	10	Nursing and Medical Records		Petersen Health Oper
23	V	12	Social Services		Petersen Health Oper
24	V	17	Administrative		Petersen Health Oper
25	V	19	Professional Services		Petersen Health Oper
26	V	20	Dues, Fees, Subs & Promotions		Petersen Health Oper
27	V	21	Clerical and General Office		Petersen Health Oper
28	V	22	Employee Benefits & Payroll		Petersen Health Oper
29	V	23	Inservice Training & Education		Petersen Health Oper
30	V	24	Travel and Seminar		Petersen Health Oper
31	V	25	Other Admin. Staff Transport.		Petersen Health Oper
32	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Oper
33	V	27	Mgmt. Allocation of Benefits		Petersen Health Oper
34	V	30	Depreciation		Petersen Health Oper
35	V	32	Interest		Petersen Health Oper
36	V	33	Real Estate Taxes		Petersen Health Oper
37	V	34	Rent-Facility and Grounds		Petersen Health Oper
38	V	35	Rent-Equipment & Vehicles		Petersen Health Oper
39	Total			\$	

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

This includes rent,
NO

accordance with

Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)
Organizations, LLC	100.00%	\$ 0	\$
Organizations, LLC	100.00%	0	
Organizations, LLC	100.00%	0	
Organizations, LLC	100.00%	0	
Organizations, LLC	100.00%	0	
Organizations, LLC	100.00%	0	
Organizations, LLC	100.00%	0	
Organizations, LLC	100.00%	0	
Organizations, LLC	100.00%	0	
Organizations, LLC	100.00%	0	
Organizations, LLC	100.00%	0	
Organizations, LLC	100.00%	37,341	37,341
Organizations, LLC	100.00%	322	322
Organizations, LLC	100.00%	1,453	1,453
Organizations, LLC	100.00%	(9)	(9)
Organizations, LLC	100.00%	0	
Organizations, LLC	100.00%	0	
Organizations, LLC	100.00%	0	
Organizations, LLC	100.00%	0	
Organizations, LLC	100.00%	0	
Organizations, LLC	100.00%	85	85
Organizations, LLC	100.00%	13,489	13,489
Organizations, LLC	100.00%	0	
Organizations, LLC	100.00%	0	
Organizations, LLC	100.00%	0	
		\$ 52,681	\$ * 52,681

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Facility Name & ID Number

McLeansboro Rehab & HCC

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizat

	1 OWNERS		2 RELATED NU
	Name	Ownership %	Name
1			Aledo Health Care Center
2			Arcola Health Care Center
3			Aspen Rehab & Health Care
4			Batavia Rehab & Health Care Cent
5			Bement Health Care Center
6			Benton Rehab & Health Care Cent
7			Bloomington Rehab & Health Care
8			Casey Health Care Center
9			Charleston Rehab & Health Care C
10			Cisne Rehab & Health Care Center
11			Countryview Care Center of Macor
12			Countryview Terrace
13			Cumberland Rehab & Health Care
14			Decatur Rehab & Health Care Cen
15			Eastside Health & Rehabilitation C
16			Eastview Terrace
17			El Paso Health Care Center
18			Enfield Rehab & Health Care Cent
19			Farmer City Rehab & Health Care
20			Flanagan Rehab & Health Care Ce
21			Flora Gardens Care Center
22			Flora Health Care Center
23			Fondulac Rehab & Health Care Ce
24			Havana Health Care Center
25			Illini Heritage Rehab & Health Car
26			Jonesboro Rehab & Health Care C
27			Kewanee Care Home
28			LaHarpe Davier Health Care Cente
29			Lebanon Care Center
30			Marigold Rehab & Health Care Ce

Locations (parties) as defined in the instructions.

NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
	City	Name	City	Type of Business
	Aledo	Petersen Companies, L	Peoria	Mgmt/Bookkeeping
	Arcola	Petersen Health Care I	Peoria	Mgmt/Bookkeeping
	Silvis	Petersen Health Care,	Peoria	Mgmt/Bookkeeping
ter	Batavia	Petersen Health Enterj	Peoria	Mgmt/Bookkeeping
	Bement	Petersen Health Opera	Peoria	Mgmt/Bookkeeping
er	Benton	Petersen Health System	Peoria	Mgmt/Bookkeeping
Center	Bloomington	Petersen Hotels LLC	Peoria	Hospitality
	Casey	Petersen Restaurants,	Peoria	Restaurant
Center	Charleston	Petersen Health Care I	Peoria	Mgmt/Bookkeeping
	Cisne	Petersen Health Care V	Peoria	Mgmt/Bookkeeping
mb	Macomb	Petersen Health Care V	Peoria	Mgmt/Bookkeeping
	Louisville	Petersen Health Care V	Sullivan	Lessor
Center	Greenup	Petersen Health Care V	Peoria	Mgmt/Bookkeeping
ter	Decatur	Petersen Health Care X	Peoria	Lessor
Center	Pittsfield	Petersen Osage Beach,	Osage Beach, MO	Lessor
	Sullivan	Petersen West Frankfo	West Frankfort	Lessor
	El Paso	Midwest Health Care,	Peoria	Mgmt/Bookkeeping
er	Enfield	Poplar Bluff Health Ca	Poplar Bluff, MO	Lessor
Center	Farmer City	Petersen Roseville, LL	Roseville	Lessor
nter	Flanagan			
	Flora			
	Flora			
nter	East Peoria			
	Havana			
ce	Champaign			
enter	Jonesboro			
	Kewanee			
er	LaHarpe			
	Lebanon			
nter	Galesburg			

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Facility Name & ID Number

McLeansboro Rehab & HCC

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizat

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

Locations (parties) as defined in the instructions.

NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
	City	Name	City	Type of Business
	Sullivan			
Center	McLeansboro			
	Mt. Vernon			
Center	Newman			
Center	Nokomis			
	North Aurora			
Center	Princeton			
	Mattoon			
	Piper City			
Center	Morrison			
Center	Polo			
Center	Prairie City			
	Brighton			
	Rochelle			
Center	Rochelle			
Center	Rock Falls			
	Rock Falls			
Center	Roseville			
Center	Rosiclare			
	Kewanee			
Center	Sandwich			
	Sandwich			
	Harrisburg			
Center	Shelbyville			
Center	South Elgin			
	Watseka			
	Sullivan			
	Canton			
	Swansea			
Center	Pekin			

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Facility Name & ID Number

McLeansboro Rehab & HCC

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations

	1 OWNERS		2 RELATED NUMBERS
	Name	Ownership %	Name
1			Toulon Health Care Center
2			Tuscola Health Care Center
3			Twin Lakes Rehab & Health Care Center
4			Vandalia Rehab & Health Care Center
5			Watseka Health Care Center
6			Westside Rehab & Care Center
7			Whispering Oaks
8			White Oak Rehab & Health Care Center
9			Willow Rose Rehab & Health Care Center
10			Sheldon Health Care Center
11			Tuscola Health Care Center
12			Effingham Health Care Center
13			Collinsville Health Care Center
14			Ozark Rehab & Health Care Center
15			South Shore Health Care, LLC
16			Cedargate Skilled Nursing Facility
17			Tarkio Rehab & Health Care Center
18			Shangri-la Rehab & Living Center
19			Prairie Rose Care Center
20			Illini Heritage Rehab & Health Center
21			Courtyard Estates of Kewanee
22			Courtyard Estates of Bradford
23			Courtyard Estates of Galva
24			Courtyard Estates of Walcott
25			Courtyard Village of Kewanee
26			Lakewood Village
27			Courtyard Estates of Monmouth
28			Riverview Estates
29			Simple Blessings
30			Courtyard Estates of Bushnell

Locations (parties) as defined in the instructions.

NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
	City	Name	City	Type of Business
	Toulon			
	Tuscola			
Center	Paris			
Center	Vandalia			
	Watseka			
	West Frankfort			
	Rosiclare			
Center	Mt. Vernon			
Center	Jerseyville			
	Sheldon			
	Tuscola			
	Effingham			
	Collinsville			
r	Osage Beach, MO			
	Gary, IN			
	Poplar Bluff, MO			
er	Tarkio, MO			
	Blue Springs, MO			
	Pana			
Center	Champaign			
	Kewanee			
	Bradford			
	Galva			
	Walcott			
	Kewanee			
	Charleston			
	Monmouth			
	Havana			
	Casey			
	Bushnell			

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Facility Name & ID Number

McLeansboro Rehab & HCC

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations

	1 OWNERS		2 RELATED NUMBERS
	Name	Ownership %	Name
1			Courtyard Estates of Canton
2			Legacy Estates of Monmouth
3			Courtyard Estates of Sullivan
4			Courtyard Estates of Peoria
5			Cornerstone Health and Rehabilitation
6			
7			
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VII. RELATED PARTIES (continued)

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

**NOTE: ALL owners (even those with less than 5% ownership) and their re
must be listed on this schedule.**

	1	2	3	4
	Name	Title	Function	Ownership Interest
1				
2				
3				
4	N/A			
5				
6				
7				
8				
9				
10				
11				
12				
13				

*** If the owner(s) of this facility or any other related parties listed above have receive
of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE ,**

**** This must include all forms of compensation paid by related entities and all
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FO
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RES**

Board of Directors.

Relatives who receive any type of compensation from this home

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
					2
					3
					4
					5
					6
					7
					8
					9
					10
					11
					12
			TOTAL	\$	13

For compensation from other nursing homes, attach a schedule detailing the name(s) and AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS

located to Schedule V of this report (i.e., management fees). FORMS OF COMPENSATION RECEIVED FROM THIS HOME, RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

VIII. ALLOCATION OF INDIRECT COSTS

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Su All
1	1	Dietary	Resident Days	1,560,986	
2	2	Food	Resident Days	1,560,986	
3	3	Housekeeping	Resident Days	1,560,986	
4	4	Laundry	Resident Days	1,560,986	
5	5	Utilities	Resident Days	1,560,986	
6	6	Maintenance	Resident Days	1,560,986	
7	7	Mgmt. Allocation of Benefits	Resident Days	1,560,986	
8	10	Nursing and Medical Records	Resident Days	1,560,986	
9	10A	Therapy	Resident Days	1,560,986	
10	15	Mgmt. Allocation of Benefits	Resident Days	1,560,986	
11	17	Administrative	Resident Days	1,560,986	
12	19	Professional Services	Resident Days	1,560,986	
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,560,986	
14	21	Clerical and General Office	Resident Days	1,560,986	
15	23	Inservice Training & Education	Resident Days	1,560,986	
16	24	Travel and Seminar	Resident Days	1,560,986	
17	25	Other Admin. Staff Transport.	Resident Days	1,560,986	
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,560,986	
19	27	Mgmt. Allocation of Benefits	Resident Days	1,560,986	
20	30	Depreciation	Resident Days	1,560,986	
21	32	Interest	Resident Days	1,560,986	
22	33	Real Estate Taxes	Resident Days	1,560,986	
23	34	Rent-Facility and Grounds	Resident Days	1,560,986	
24	35	Rent-Equipment & Vehicles	Resident Days	1,560,986	
25	TOTALS				

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

5	6	7	8	9
Number of ibunits Being ocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6
75	\$ 307,592	\$ 295,212	7,757	\$ 1,529
75	6,577	0	7,757	33
75	3,057	0	7,757	15
75	0	0	7,757	0
75	23,338	0	7,757	116
75	150,672	97,358	7,757	749
75	17,394	0	7,757	86
75	1,082	0	7,757	5
75	0	0	7,757	0
75	0	0	7,757	0
75	4,578,456	4,578,456	7,757	48,847
75	648,504	0	7,757	3,223
75	41,231	0	7,757	205
75	3,812,055	3,383,297	7,757	18,943
75	6,148	0	7,757	31
75	313	0	7,757	2
75	284,745	0	7,757	1,415
75	54,993	0	7,757	273
75	352,851	0	7,757	1,753
75	252,711	0	7,757	1,256
75	420,365	0	7,757	2,089
75	24,742	0	7,757	123
75	0	0	7,757	0
75	45,546	0	7,757	226
	\$ 11,032,372	\$ 8,354,323		\$ 80,919

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VIII. ALLOCATION OF INDIRECT COSTS

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Su All
1	1	Dietary	Resident Days	408,598	
2	2	Food	Resident Days	408,598	
3	3	Housekeeping	Resident Days	408,598	
4	4	Laundry	Resident Days	408,598	
5	5	Utilities	Resident Days	408,598	
6	6	Maintenance	Resident Days	408,598	
7	7	Mgmt. Allocation of Benefits	Resident Days	408,598	
8	10	Nursing and Medical Records	Resident Days	408,598	
9	12	Social Services	Resident Days	408,598	
10	17	Administrative	Resident Days	408,598	
11	19	Professional Services	Resident Days	408,598	
12	20	Dues, Fees, Subs & Promotions	Resident Days	408,598	
13	21	Clerical and General Office	Resident Days	408,598	
14	22	Employee Benefits & Payroll	Resident Days	408,598	
15	23	Inservice Training & Education	Resident Days	408,598	
16	24	Travel and Seminar	Resident Days	408,598	
17	25	Other Admin. Staff Transport.	Resident Days	408,598	
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	408,598	
19	27	Mgmt. Allocation of Benefits	Resident Days	408,598	
20	30	Depreciation	Resident Days	408,598	
21	32	Interest	Resident Days	408,598	
22	33	Real Estate Taxes	Resident Days	408,598	
23	34	Rent-Facility and Grounds	Resident Days	408,598	
24	35	Rent-Equipment & Vehicles	Resident Days	408,598	
25	TOTALS				

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IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required
		YES	NO		
	A. Directly Facility Related				
	Long-Term				
1	Bank of America		X	Mortgage	Varies
2					
3					
4					
5					
	Working Capital				
6					
7					
8					
9	TOTAL Facility Related				
	B. Non-Facility Related*				
10					
11					
12					
13					
14	TOTAL Non-Facility Related				
15	TOTALS (line 9+line14)				

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sc

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

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

necessary.)

5	6		7	8	9	10	
Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
	Original	Balance					
1/19/07	\$ 650,000	\$ 484,932	12/31/13	Varies	\$ 17,501	1	
						2	
						3	
						4	
						5	
						6	
						7	
						8	
	\$ 650,000	\$ 484,932			\$ 17,501	9	
						10	
					(6,022)	11	
					2,089	12	
					13,489	13	
	\$	\$			\$ 9,556	14	
	\$ 650,000	\$ 484,932			\$ 27,057	15	

ch. V. \$ _____ Line # _____

requently, page 4, col. 7.

in column 2.

Facility Name & ID Number **McLeansboro Rehab & HCC**

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

B. Real Estate Taxes

Important, please see the next worksheet statement and bill must accompany

1. Real Estate Tax accrual used on 2012 report.

2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, list each year.)

3. Under or (over) accrual (line 2 minus line 1).

4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)

5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general and administrative expenses. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the denial.)**

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.

TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the refund check.)

7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2008	7,243	8
	2009	7,299	9
	2010	7,511	10
	2011	7,405	11
	2012	7,173	12

Accrual based on prior year tax bill.

NOTES:

1. Please indicate a negative number by use of brackets (). Do not include taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must file an application for real estate tax exemption unless the building is exempt. **This denial must be no more than four years old at the time of the application.**

sheet, "RE_Tax". The real estate tax the cost report.		\$	7,632	1
overs more than one year, detail below.)	2012	\$	7,173	2
		\$	(459)	3
nes below.)		\$	7,392	4
eneral operating costs on Schedule V, sections A, B or C. :opy of the appeal filed with the county.)		\$		5
Home Office Allocation real estate tax appeal board's decision.)		\$	123	6
		\$	7,056	7

	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

duct any overaccrual of

st attach a denial of an
is rented from a for-profit entity.
t the time the cost report is filed.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 11,840 B. General Construction Type: Exterior

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipr
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Sched

E. List all other business entities owned by this operating entity or related to the operating entity that a
 (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, ind
 List entity name, type of business, square footage, and number of beds/units available (where applic

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 If so, please complete the following:

1. Total Amount Incurred: _____

3. Current Period Amortization: _____

Nature of Costs: _____
 (Attach a complete schedule detailing the total amount o

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet
1	<u>Facility</u>	<u>56,628</u>
2		
3	TOTALS	56,628

Brick Frame Fire Resistant Number of Stories 1

Related Organization. (c) Rent from Completely Unrelated Organization.

e XI or Schedule XII-A. See instructions.)

ment from a Related Organization. (X) (c) Rent equipment from Completely Unrelated Organization.

rule XI-C or Schedule XII-B. See instructions.)

re located on or adjacent to this nursing home's grounds
dependent living facilities, CNA training facilities, etc.)
able).

Horizontal lines for text entry.

YES NO

2. Number of Years Over Which it is Being Amortized:

4. Dates Incurred:

of organization and pre-operating costs.)

Table with 4 columns: Year Acquired, Cost, and two unlabeled columns. Row 1: 2005, \$40,500, 1. Row 2: 2. Row 3: \$40,500, 3.

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.)

	1		2	3	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	
4	73		2005	1973	\$
5					
6					
7					
8					
	Improvement Type**				
9	Original Land Improvements			2005	
10	Water Tap			2007	
11	Sprinkler System			2007	
12	Grease Trap			2007	
13	Drain Tank			2007	
14	Fire Alarm			2007	
15	Roof repair			2008	
16	Asphalt in Parking Lot			2010	
17	Nurses Station Annunciator Visual Panel			2010	
18	Water Heater			2011	
19	Water Heater			2012	
20	Water Heater			2012	
21	Hot Water Tank			2013	
22	Rooftop Air Conditioner			2013	
23					
24					
25					
26					
27					
28					
29					
30	Land Improvements Booked				
31	Building Booked				
32	Building Improvement Booked				
33					
34	2013-Home Office Allocation-Building Improvements				
35	2013-Home Office Allocation-Land Improvements				
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.

9	
Accumulated depreciation	
247,350	4
	5
	6
	7
	8
7,931	9
1,085	10
16,965	11
1,768	12
201	13
1,859	14
1,683	15
1,876	16
2,345	17
1,235	18
825	19
786	20
564	21
249	22
	23
	24
	25
	26
	27
	28
	29
	30
	31
	32
	33
	34
	35
	36

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.)

1	3	
Improvement Type**	Year Constructed	
37		\$
38		
39		
40		
41		
42		
43		
44		
45		
46		
47		
48		
49		
50		
51		
52		
53		
54		
55		
56		
57		
58		
59		
60		
61		
62		
63		
64		
65		
66		
67		
68		
69		
70	TOTAL (lines 4 thru 69)	\$

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

9	
Accumulated	
depreciation	
	37
	38
	39
	40
	41
	42
	43
	44
	45
	46
	47
	48
	49
	50
	51
	52
	53
	54
	55
	56
	57
	58
	59
	60
	61
	62
	63
	64
	65
	66
	67
	68
	69
286,722	70

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	2
71	Purchased in Prior Years	\$ 28,112	\$
72	Current Year Purchases		
73	Fully Depreciated Assets	144,430	
74	Home Office Allocation		
75	TOTALS	\$ 172,542	\$

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost
76				\$
77	N/A			
78				
79				
80	TOTALS			\$

E. Summary of Care-Related Assets

		Re
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) +
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B th
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B th
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B th
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B th

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		\$	\$	\$
87	N/A			
88				
89				
90				
91	TOTALS	\$	\$	\$

Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
2,079	\$ 2,741	\$ 662	5-10 yrs.	\$ 19,754	71
			10 yrs.		72
				144,430	73
	1,232	1,232			74
2,079	\$ 3,973	\$ 1,894		\$ 164,184	75

Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
\$	\$	\$		\$	76
					77
					78
					79
\$	\$	\$		\$	80

1	2	
Reference	Amount	
(Pages 12B thru 12I, if applicable)	\$ 1,055,742	81
ru 12I, if applicable)	\$ 38,143	82
ru 12I, if applicable)	\$ 41,374	83
ru 12I, if applicable)	\$ 3,231	84
ru 12I, if applicable)	\$ 450,906	85

**

G. Construction-in-Progress

	Description	Cost	
86	92	\$	92
87	93 N/A		93
88	94		94
89	95	\$	95
90			
91			

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, c
 If NO, see instructions.

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

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?

16. Rental Amount for movable equipment: \$ 13,160 Description: See A

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	
17	Facility	2006 Ford E250	\$ 578.17	\$
18				
19				
20				
21	TOTAL		\$ 578.17	\$

column 4?

YES NO

5 Total Years of Lease	6 Total Years Renewal Option*	
		3
		4
		5
		6
		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 \$ _____

_____ *

YES NO

attached Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

4 Rental Expense for this Period	
6,938	17
	18
	19
	20
6,938	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.

McLeansboro Rehab & HCC

0047498

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	\$	5,498
Dishwasher		734
Laundry Equipment		-
Copier		6,702
Home Office Allocation		226
		<u>13,160</u>

Facility Name & ID Number McLeansboro Rehab & HCC

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See inst

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a sch

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p style="text-align: right;"> <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 PO</p> <p>IN-HOUSE PROG</p> <p>IN OTHER FACII</p> <p>COMMUNITY CC</p> <p>HOURS PER CNA</p>
--	---

B. EXPENSES

ALLOCATION OF COSTS

		Facility		
		1 Drop-outs	2 Completed	
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)	\$		

- (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.

(Instructions.)

(Schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>PORTION:</p> <p>PROGRAM <input type="checkbox"/></p> <p>CITY <input type="checkbox"/></p> <p>COLLEGE <input type="checkbox"/></p> <p>_____</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>
--	--

C. CONTRACTUAL INCOME

(d)

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

3	4
Contract	Total
	\$
	\$

\$

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	

(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	Schedule V Line & Column Reference	2	
			Units of Service	Staff
1	Licensed Occupational Therapist	10A(3)	hrs	\$
2	Licensed Speech and Language Development Therapist	10A(3)	hrs	
3	Licensed Recreational Therapist		hrs	
4	Licensed Physical Therapist	10A(3)	hrs	
5	Physician Care		visits	
6	Dental Care		visits	
7	Work Related Program		hrs	
8	Habilitation		hrs	
9	Pharmacy	39(2)	# of prescripts	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs	
11	Academic Education		hrs	
12	Other (specify):			
13	Other (specify):			
14	TOTAL			\$

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners on this schedule. Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with treatment on this schedule.

STATE OF ILLINOIS

0047498 Report Period Beginning:

1/1/2013 Ending:

3	4		5	6	7	To
Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	To (Col.	(Col.
	Units	Cost				
	1,718	\$ 25,769	\$	1,718	\$	
	688	10,313		688		
	3,072	46,085		3,072		
			27,786			
	5,478	\$ 82,167	\$ 27,786	5,478	\$	

ners. Consultant fees should be detailed on
 he above activities should not be listed

8

otal Cost (.3 + 5 + 6)	
25,769	1
10,313	2
	3
46,085	4
	5
	6
	7
	8
27,786	9
	10
	11
	12
	13
109,953	14

Facility Name & ID Number McLeansboro Rehab & HCC**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of

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	\$ (87,552)	\$ (87,552)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>41,000</u>)	171,895	171,895	3
4	Supply Inventory (priced at _____)	7,186	7,186	4
5	Short-Term Investments			5
6	Prepaid Insurance	15,340	15,340	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): _____			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 106,869	\$ 106,869	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	65,041	40,500	13
14	Buildings, at Historical Cost	727,500	731,147	14
15	Leasehold Improvements, at Historical Cost	86,672	111,553	15
16	Equipment, at Historical Cost	172,542	172,542	16
17	Accumulated Depreciation (book methods)	(440,325)	(450,906)	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)	\$ 611,430	\$ 604,836	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 718,299	\$ 711,705	25

*(See in

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 302,516	\$ 302,516	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	15,574	15,574	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,682	2,682	31
32	Accrued Real Estate Taxes(Sch.IX-B)	7,392	7,392	32
33	Accrued Interest Payable	1,323	1,323	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	20,951	20,951	36
37	<u>Accrued Management Fees</u>	120,535	120,535	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 470,973	\$ 470,973	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	484,932	484,932	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Intercompany Loans</u>	502,357	502,357	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 987,289	\$ 987,289	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,458,262	\$ 1,458,262	46
47	TOTAL EQUITY (page 18, line 24)	\$ (739,963)	\$ (746,557)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 718,299	\$ 711,705	48

(instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

1	Balance at Beginning of Year, as Previously Reported	\$
2	Restatements (describe):	
3	Nursing Supplies entered after CR completed	
4		
5		
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$
	A. Additions (deductions):	
7	NET Income (Loss) (from page 19, line 43)	
8	Aquisitions of Pooled Companies	
9	Proceeds from Sale of Stock	
10	Stock Options Exercised	
11	Contributions and Grants	
12	Expenditures for Specific Purposes	
13	Dividends Paid or Other Distributions to Owners	(
14	Donated Property, Plant, and Equipment	
15	Other (describe)	
16	Other (describe)	
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$
	B. Transfers (Itemize):	
18		
19		
20		
21		
22		
23	TOTAL Transfers (sum of lines 18-22)	\$
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$

1	
Total	
(381,563)	1
	2
393	3
	4
	5
(381,170)	6
(358,793)	7
	8
	9
	10
	11
	12
)	13
	14
	15
	16
(358,793)	17
	18
	19
	20
	21
	22
	23
(739,963)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number McLeansboro Rehab & HCC

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule
classifications of revenue and expense must be provided on this form, even if financial statement
Note: This schedule should show gross revenue and expenses. Do not net revenue

1

I. Revenue		Amount		
A. Inpatient Care				
1	Gross Revenue -- All Levels of Care	\$ 1,011,992	1	31
2	Discounts and Allowances for all Levels	(91,031)	2	32
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 920,961	3	33
B. Ancillary Revenue				
4	Day Care		4	34
5	Other Care for Outpatients		5	
6	Therapy	129,214	6	35
7	Oxygen	258	7	36
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 129,472	8	
C. Other Operating Revenue				
9	Payments for Education		9	37
10	Other Government Grants		10	38
11	CNA Training Reimbursements		11	39
12	Gift and Coffee Shop		12	40
13	Barber and Beauty Care		13	
14	Non-Patient Meals	925	14	41
15	Telephone, Television and Radio		15	
16	Rental of Facility Space		16	42
17	Sale of Drugs	44,300	17	
18	Sale of Supplies to Non-Patients		18	43
19	Laboratory		19	
20	Radiology and X-Ray	5,734	20	
21	Other Medical Services	1,092	21	44
22	Laundry		22	45
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 52,051	23	46
D. Non-Operating Revenue				
24	Contributions		24	47
25	Interest and Other Investment Income****	6,022	25	48
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 6,022	26	49
E. Other Revenue (specify):****				
27	Settlement Income (Insurance, Legal, Etc.)		27	*
28	<u>Miscellaneous Revenue</u>	58	28	**
28a	<u>Transportation Revenue</u>	2,877	28a	***
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,935	29	
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,111,441	30	****]

Report Period Beginning: 1/1/2013

Ending: 12/31/2013

ule to Schedules V and VI.) All required

ents are attached.

against expense.

2

II. Expenses	Amount	
A. Operating Expenses		
General Services	317,985	31
Health Care	604,868	32
General Administration	330,978	33
B. Capital Expense		
Ownership	82,449	34
C. Ancillary Expense		
Special Cost Centers	69,517	35
Provider Participation Fee	64,437	36
D. Other Expenses (specify):		
		37
		38
		39
TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,470,234	40
Income before Income Taxes (line 30 minus line 40)**	(358,793)	41
Income Taxes		42
NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (358,793)	43

III. Net Inpatient Revenue detailed by Payer Source		
Medicaid - Net Inpatient Revenue	\$ 517,872	44
Private Pay - Net Inpatient Revenue	222,673	45
Medicare - Net Inpatient Revenue	181,633	46
Other-(specify)		47
Other-(specify) Charity Contractual Allowance	(1,217)	48
TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 920,961	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.

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	1,993	1,993	\$ 52,002	\$ 26.09
2	Assistant Director of Nursing				
3	Registered Nurses	3,176	3,215	73,675	22.92
4	Licensed Practical Nurses	5,220	5,423	99,756	18.39
5	CNAs & Orderlies	11,025	15,543	171,040	11.00
6	CNA Trainees				
7	Licensed Therapist				
8	Rehab/Therapy Aides				
9	Activity Director	1,581	1,718	21,520	12.53
10	Activity Assistants				
11	Social Service Workers	1,993	1,993	29,388	14.75
12	Dietician				
13	Food Service Supervisor	1,178	1,301	18,088	13.90
14	Head Cook				
15	Cook Helpers/Assistants	6,201	6,578	68,043	10.34
16	Dishwashers				
17	Maintenance Workers	1,975	2,007	29,770	14.83
18	Housekeepers	3,359	3,544	36,464	10.29
19	Laundry	1,647	1,754	15,952	9.09
20	Administrator	2,080	2,080	48,847	23.48
21	Assistant Administrator				
22	Other Administrative				
23	Office Manager	1,400	1,575	26,580	16.88
24	Clerical				
25	Vocational Instruction				
26	Academic Instruction				
27	Medical Director				
28	Qualified MR Prof. (QMRP)				
29	Resident Services Coordinator				
30	Habilitation Aides (DD Homes)				
31	Medical Records				
32	Other Health Care <u>Transportation</u>	4	4	43	10.75
33	Other(specify) <u>CPC</u>	1,356	1,420	29,918	21.07
34	TOTAL (lines 1 - 33)	44,188	50,148	\$ 721,086 *	\$ 14.38

* 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	
1					
2	35	Dietary Consultant	46	\$ 2,313	L1, C3
3	36	Medical Director	Monthly	7,800	L9, C3
4	37	Medical Records Consultant			
5	38	Nurse Consultant			
6	39	Pharmacist Consultant	Monthly	1,556	L10, C3
7	40	Physical Therapy Consultant			
8	41	Occupational Therapy Consultant			
9	42	Respiratory Therapy Consultant	3	165	L10, C3
10	43	Speech Therapy Consultant			
11	44	Activity Consultant			
12	45	Social Service Consultant			
13	46	Other(specify)			
14	47				
15	48				
16					
17	49	TOTAL (lines 35 - 48)	49	\$ 11,834	

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
23					
24					
25					
26					
27	50	Registered Nurses		\$	
28	51	Licensed Practical Nurses			
29	52	Certified Nurse Assistants/Aides			
30					
31	53	TOTAL (lines 50 - 52)		\$	
32					
33					
34					

35
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44
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49

50
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53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries		Ownership	
Name	Function	%	Amount
Loretta Ellis	Administrator	0	\$ 48,847
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 48,847
B. Administrative - Other			
Description			Amount
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 121,000
_____			_____
_____			_____
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 121,000
C. Professional Services			
Vendor/Payee	Type		Amount
E-Health Data Solutions	Computer Services		\$ 6,763
Honkamp Krueger & Co.	Accounting Fees		384
Hamilton County Comm.	Computer Services		72
Gail and Rice	Accounting Fees		614
_____	_____		_____
_____	_____		_____
_____	_____		_____
_____	_____		_____
_____	_____		_____
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 7,833

Promotions	
	Amount
	\$ 3,980
nt	69
Check	
)	
56	565
	295
as	0
	527
	()
	()
	()
.V,	\$ 5,436

r**	
	Amount
	\$
	2
	()
	\$ 2

McLeansboro Rehab & HCC**0047498****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)		7,833
Home Office Allocation		
SmithAmundsen	Legal	192
Cole, Schotz, Meisel	Legal	105
Black, Hedin, Ballard	Legal	10
Elias, Meginnes, Riffle & Seghetti	Legal	19
Miller, Hall, and Triggs	Legal	403
Evapar	Legal	78
Ginoli & Company	Accountants	1109
E-Health Data Solutions	Computer Services	1379
Miscellaneous	Computer Services	30
Odessian LLC	Computer Services	15
CCH	Computer Services	4
Lexis-Nexis	Computer Services	2
Ipanema Solutions	Computer Services	4
Macquarie Technology Services	Computer Services	27
Advanced Answers on Demand	Computer Services	1418
TeamViewer	Computer Services	5
Stratus Networks	Computer Services	114
Kemper Technology	Computer Services	88
AT&T	Computer Services	2
Medifax	Computer Services	13
Vision Share/Ability Network	Computer Services	194
Barracuda	Computer Services	35
CIAN	Computer Services	47
Comcast	Computer Services	10
Emdeon	Computer Services	16
Marotta Gund Budd & Dzera	Other Prof Fees	34625
David Budde	Other Prof Fees	9
Pharmacy Price Mangement	Other Prof Fees	179
All Scripts	Other Prof Fees	318
Registered Agent Solutions	Other Prof Fees	15
Healthink	Other Prof Fees	99
Total (agree to Schedule V, line 19, column 8)		<u><u>48,397</u></u>

Facility Name & ID Number McLeansboro Rehab & HCC

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in S
(See instructions.)**

	1	2	3	4	5		6
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	
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 **McLeansboro Rehab & HCC**

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?
If YES, give association name and amount. No
- (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?
What was the average life used for new equipment added during this period? Yes
10 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. \$ 8,081 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. \$ 64,437
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.

0047498

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

- (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. \$ 925
- (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. \$ 2,877
- 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.