

		FOR BHF USE					

LL1

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY 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 PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0047506

Facility Name: Newman Rehabilitation & Health Care Center

Address: 418 South Memorial Park Drive Newman 61942
Number City Zip Code

County: Douglas

Telephone Number: (217) 837-2421 Fax # (217) 837-2631

HFS ID Number:

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

Type of Ownership:

VOLUNTARY, NON-PROFIT
Charitable Corp.
Trust
IRS Exemption Code

X PROPRIETARY
Individual
Partnership
Corporation
"Sub-S" Corp.
X Limited Liability Co.
Trust
Other

GOVERNMENTAL
State
County
Other

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2012 to 12/31/2012 and certify to the best of my knowledge and belief that the said contents 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.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed)
(Type or Print Name) Mark B. Petersen
(Title) Chief Executive Officer

Paid Preparer

(Signed)
(Print Name and Title)
(Firm Name & Address)
(Telephone) () Fax # ()

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Newman Rehabilitation & Health Care Center# 0047506 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed bedsN/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	<u>60</u>	Skilled (SNF)	<u>60</u>	<u>21,900</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>60</u>	TOTALS	<u>60</u>	<u>21,900</u>	7

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	<u>9,804</u>	<u>5,735</u>	<u>1,759</u>	<u>17,298</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>9,804</u>	<u>5,735</u>	<u>1,759</u>	<u>17,298</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 78.99%

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?

YesG. 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

60

and days of care provided

1,517Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL

☒

MODIFIED

CASH*

☐

CASH*

☐

Is your fiscal year identical to your tax year?

YES

☒NO ☐Tax Year: 12/31/12Fiscal Year: 12/31/12

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total						
		1	2	3	4	5	6	7	8	9	10
	A. General Services										
1	Dietary	108,255	9,720		117,975		117,975	3,149	121,124		1
2	Food Purchase		88,296		88,296		88,296	(1,687)	86,609		2
3	Housekeeping	87,842	15,057		102,899		102,899	24	102,923		3
4	Laundry	16,962	17,266		34,228		34,228	4	34,232		4
5	Heat and Other Utilities			45,472	45,472		45,472	248	45,720		5
6	Maintenance	38,080	6,639	19,189	63,908		63,908	1,747	65,655		6
7	Other (specify):* Home Off. Ben. All.							419	419		7
8	TOTAL General Services	251,139	136,978	64,661	452,778		452,778	3,904	456,682		8
	B. Health Care and Programs										
9	Medical Director			11,000	11,000		11,000		11,000		9
10	Nursing and Medical Records	711,191	85,388	(2,835)	793,744		793,744	30	793,774		10
10a	Therapy			229,559	229,559		229,559		229,559		10a
11	Activities	27,291	27	295	27,613		27,613	(427)	27,186		11
12	Social Services	26,402			26,402		26,402		26,402		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.										15
16	TOTAL Health Care and Programs	764,884	85,415	238,019	1,088,318		1,088,318	(397)	1,087,921		16
	C. General Administration										
17	Administrative			187,000	187,000		187,000	(129,481)	57,519		17
18	Directors Fees										18
19	Professional Services			121,000	121,000		121,000	73,614	194,614		19
20	Dues, Fees, Subscriptions & Promotions			3,790	3,790		3,790	279	4,069		20
21	Clerical & General Office Expenses	25,653	5,033	14,325	45,011		45,011	36,437	81,448		21
22	Employee Benefits & Payroll Taxes			153,954	153,954		153,954		153,954		22
23	Inservice Training & Education							59	59		23
24	Travel and Seminar							6	6		24
25	Other Admin. Staff Transportation			7,937	7,937		7,937	4,120	12,057		25
26	Insurance-Prop.Liab.Malpractice			25,938	25,938		25,938	673	26,611		26
27	Other (specify):* Home Off. Ben. All.							8,408	8,408		27
28	TOTAL General Administration	25,653	5,033	513,944	544,630		544,630	(5,885)	538,745		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,041,676	227,426	816,624	2,085,726		2,085,726	(2,378)	2,083,348		29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			9,898	9,898		9,898	3,992	13,890			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			23,306	23,306		23,306	47,605	70,911			32
33	Real Estate Taxes			22,268	22,268		22,268	446	22,714			33
34	Rent-Facility & Grounds			203,350	203,350		203,350		203,350			34
35	Rent-Equipment & Vehicles			18,634	18,634		18,634	491	19,125			35
36	Other (specify):*											36
37	TOTAL Ownership			277,456	277,456		277,456	52,534	329,990			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		52,095		52,095		52,095		52,095			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			186,311	186,311		186,311		186,311			42
43	Other (specify):* Non-allowable Costs		781	16,517	17,298		17,298	(17,298)				43
44	TOTAL Special Cost Centers		52,876	202,828	255,704		255,704	(17,298)	238,406			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,041,676	280,302	1,296,908	2,618,886		2,618,886	32,858	2,651,744			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	(1,793)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,694)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	891	30		9
10	Interest and Other Investment Income	(932)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(111)	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	(7,255)	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	(1,479)	43		24
25	Fund Raising, Advertising and Promotional	(1,089)	43		25
	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	(5,263)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (19,725)		\$	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 Amount	2 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)	52,583	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 52,583		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 32,858		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 Yes	2 No	3 Amount	4 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

STATE OF ILLINOIS
Newman Rehabilitation & Health Care Center

Page 5A

ID# 0047506
Report Period Beginning: 1/1/2012
Ending: 12/31/2012

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Labs-Part A	\$ (2,225)	43	1
2	X-Rays-Part A	(1,851)	43	2
3	Offset Miscellaneous Office Supplies Revenue	(166)	21	3
4	Resident Flower	(200)	43	4
5	Disallowed Special Events	(394)	43	5
6	Offset Transportation Revenue	(427)	11	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	(5,263)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Newman Rehabilitation & Health Care Center

0047506

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	3,149	0	0	0	0	0	0	0	0	0	3,149	1
2	Food Purchase	(1,793)	106	0	0	0	0	0	0	0	0	0	(1,687)	2
3	Housekeeping	0	24	0	0	0	0	0	0	0	0	0	24	3
4	Laundry	0	4	0	0	0	0	0	0	0	0	0	4	4
5	Heat and Other Utilities	0	248	0	0	0	0	0	0	0	0	0	248	5
6	Maintenance	0	1,747	0	0	0	0	0	0	0	0	0	1,747	6
7	Other (specify):*	0	419	0	0	0	0	0	0	0	0	0	419	7
8	TOTAL General Services	(1,793)	5,697	0	0	0	0	0	0	0	0	0	3,904	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	30	0	0	0	0	0	0	0	0	0	30	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(427)	0	0	0	0	0	0	0	0	0	0	(427)	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	(427)	30	0	0	0	0	0	0	0	0	0	(397)	16
	C. General Administration													
17	Administrative	0	(129,481)	0	0	0	0	0	0	0	0	0	(129,481)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	17,009	0	56,605	0	0	0	0	0	0	0	73,614	19
20	Fees, Subscriptions & Promotions	0	0	242	37	0	0	0	0	0	0	0	279	20
21	Clerical & General Office Expenses	(166)	0	35,643	960	0	0	0	0	0	0	0	36,437	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	59	0	0	0	0	0	0	0	0	59	23
24	Travel and Seminar	0	0	6	0	0	0	0	0	0	0	0	6	24
25	Other Admin. Staff Transportation	0	0	4,084	36	0	0	0	0	0	0	0	4,120	25
26	Insurance-Prop.Liab.Malpractice	0	0	673	0	0	0	0	0	0	0	0	673	26
27	Other (specify):*	0	0	8,408	0	0	0	0	0	0	0	0	8,408	27
28	TOTAL General Administration	(166)	(112,472)	49,115	57,638	0	0	0	0	0	0	0	(5,885)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(2,386)	(106,745)	49,115	57,638	0	0	0	0	0	0	0	(2,378)	29

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	891	0	3,026	75	0	0	0	0	0	0	0	3,992	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(932)	0	6,015	42,522	0	0	0	0	0	0	0	47,605	32
33	Real Estate Taxes	0	0	446	0	0	0	0	0	0	0	0	446	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	443	48	0	0	0	0	0	0	0	491	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(41)	0	9,930	42,645	0	0	0	0	0	0	0	52,534	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):*	(17,298)	0	0	0	0	0	0	0	0	0	0	(17,298)	43
44	TOTAL Special Cost Centers	(17,298)	0	0	0	0	0	0	0	0	0	0	(17,298)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(19,725)	(106,745)	59,045	100,283	0	0	0	0	0	0	0	32,858	45

VII. RELATED PARTIES

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

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

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

☒ YES ☐ NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 3,149	\$ 3,149	1
2	V	2	Food		Petersen Health Care, Inc.	100.00%	106	106	2
3	V	3	Housekeeping		Petersen Health Care, Inc.	100.00%	24	24	3
4	V	4	Laundry		Petersen Health Care, Inc.	100.00%	4	4	4
5	V	5	Utilities		Petersen Health Care, Inc.	100.00%	248	248	5
6	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	1,747	1,747	6
7	V	7	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	419	419	7
8	V	10	Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	30	30	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	187,000	Petersen Health Care, Inc.	100.00%	57,519	(129,481)	11
12	V	19	Professional Services		Petersen Health Care, Inc.	100.00%	17,009	17,009	12
13	V								13
14	Total			\$ 187,000			\$ 80,255	\$ * (106,745)	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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		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%	\$ 242	\$	242 15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	35,643		35,643 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%	6		6 18
19	V	25 Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	4,084		4,084 19
20	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	673		673 20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	8,408		8,408 21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	3,026		3,026 22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	6,015		6,015 23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	446		446 24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0		0 25
26	V	35 Rent-Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	443		443 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		\$			\$ 59,045	\$ *	59,045 39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	\$	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%	56,605	56,605	25
26	V	20	Dues, Fees, Subs & Promotions		Petersen Health Operations, LLC	100.00%	37	37	26
27	V	21	Clerical and General Office		Petersen Health Operations, LLC	100.00%	960	960	27
28	V	22	Employee Benefits & Payroll		Petersen Health Operations, LLC	100.00%	0		28
29	V	23	Inservice Training & Education		Petersen Health Operations, LLC	100.00%	0		29
30	V	24	Travel and Seminar		Petersen Health Operations, LLC	100.00%	0		30
31	V	25	Other Admin. Staff Transport.		Petersen Health Operations, LLC	100.00%	36	36	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%	75	75	34
35	V	32	Interest		Petersen Health Operations, LLC	100.00%	42,522	42,522	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%	48	48	38
39	Total			\$			\$ 100,283	\$ * 100,283	39

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

Facility Name & ID Number Newman Rehabilitation & Health Care Center # 0047506 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Aledo Health Care Center	Aledo	Petersen Companies, I	Peoria	Mgmt/Bookkeeping	1
2			Arcola Health Care Center	Arcola	Petersen Health Care I	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 Frankfo	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

Newman Rehabilitation & Health Care Center

0047506

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

VII. RELATED PARTIES

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

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

Facility Name & ID Number

Newman Rehabilitation & Health Care Center

0047506

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

VII. RELATED PARTIES

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

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

VII. RELATED PARTIES

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

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

Facility Name & ID Number Newman Rehabilitation & Health Care Cen # 0047506 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1											1
2											2
3											3
4	N/A										4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Newman Rehabilitation & Health Care Center# 0047506

Report Period Beginning:

1/1/2012Ending: 2/31/2012

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	1,569,393	74	\$ 285,707	\$ 284,214	17,297	\$ 3,149	1
2	2	Food	Resident Days	1,569,393	74	9,632	0	17,297	106	2
3	3	Housekeeping	Resident Days	1,569,393	74	2,201	0	17,297	24	3
4	4	Laundry	Resident Days	1,569,393	74	397	0	17,297	4	4
5	5	Utilities	Resident Days	1,569,393	74	22,546	0	17,297	248	5
6	6	Maintenance	Resident Days	1,569,393	74	158,485	73,431	17,297	1,747	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,569,393	74	38,057	0	17,297	419	7
8	10	Nursing and Medical Records	Resident Days	1,569,393	74	2,750	0	17,297	30	8
9	10A	Therapy	Resident Days	1,569,393	74	0	0	17,297	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,569,393	74	0	0	17,297	0	10
11	17	Administrative	Resident Days	1,569,393	74	4,353,655	4,353,655	17,297	57,519	11
12	19	Professional Services	Resident Days	1,569,393	74	1,543,275	0	17,297	17,009	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,569,393	74	21,988	0	17,297	242	13
14	21	Clerical and General Office	Resident Days	1,569,393	74	3,233,970	2,816,787	17,297	35,643	14
15	23	Inservice Training & Education	Resident Days	1,569,393	74	5,397	0	17,297	59	15
16	24	Travel and Seminar	Resident Days	1,569,393	74	535	0	17,297	6	16
17	25	Other Admin. Staff Transport.	Resident Days	1,569,393	74	370,568	0	17,297	4,084	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,569,393	74	61,077	0	17,297	673	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,569,393	74	762,912	0	17,297	8,408	19
20	30	Depreciation	Resident Days	1,569,393	74	274,514	0	17,297	3,026	20
21	32	Interest	Resident Days	1,569,393	74	545,764	0	17,297	6,015	21
22	33	Real Estate Taxes	Resident Days	1,569,393	74	40,424	0	17,297	446	22
23	34	Rent-Facility and Grounds	Resident Days	1,569,393	74	0	0	17,297	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,569,393	74	40,223	0	17,297	443	24
25	TOTALS					\$ 11,774,077	\$ 7,528,087		\$ 139,300	25

Facility Name & ID Number Newman Rehabilitation & Health Care Center# 0047506

Report Period Beginning:

1/1/2012Ending: 2/31/2012

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	404,785	21	\$	\$	17,297	\$	1
2	2	Food	Resident Days	404,785	21			17,297		2
3	3	Housekeeping	Resident Days	404,785	21			17,297		3
4	4	Laundry	Resident Days	404,785	21			17,297		4
5	5	Utilities	Resident Days	404,785	21			17,297		5
6	6	Maintenance	Resident Days	404,785	21			17,297		6
7	7	Mgmt. Allocation of Benefits	Resident Days	404,785	21			17,297		7
8	10	Nursing and Medical Records	Resident Days	404,785	21			17,297		8
9	12	Social Services	Resident Days	404,785	21			17,297		9
10	17	Administrative	Resident Days	404,785	21			17,297		10
11	19	Professional Services	Resident Days	404,785	21	1,324,676		17,297	56,605	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	404,785	21	876		17,297	37	12
13	21	Clerical and General Office	Resident Days	404,785	21	22,478		17,297	960	13
14	22	Employee Benefits & Payroll	Resident Days	404,785	21			17,297		14
15	23	Inservice Training & Education	Resident Days	404,785	21			17,297		15
16	24	Travel and Seminar	Resident Days	404,785	21			17,297		16
17	25	Other Admin. Staff Transport.	Resident Days	404,785	21	849		17,297	36	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	404,785	21			17,297		18
19	27	Mgmt. Allocation of Benefits	Resident Days	404,785	21			17,297		19
20	30	Depreciation	Resident Days	404,785	21	1,761		17,297	75	20
21	32	Interest	Resident Days	404,785	21	995,096		17,297	42,522	21
22	33	Real Estate Taxes	Resident Days	404,785	21			17,297		22
23	34	Rent-Facility and Grounds	Resident Days	404,785	21			17,297		23
24	35	Rent-Equipment & Vehicles	Resident Days	404,785	21	1,130		17,297	48	24
25	TOTALS					\$ 2,346,866	\$		\$ 100,283	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	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	1/19/07	\$ 300,000	\$ 280,244	12/31/13	Varies	\$ 23,306	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 300,000	\$ 280,244			\$ 23,306	9	
	B. Non-Facility Related*												
10												10	
11								Interest Income Offset			(932)	11	
12								Home Office Allocation-PHC			6,015	12	
13								Home Office Allocation-PHO			42,522	13	
14	TOTAL Non-Facility Related						\$	\$			\$ 47,605	14	
15	TOTALS (line 9+line14)						\$ 300,000	\$ 280,244			\$ 70,911	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

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

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

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

B. Real Estate Taxes

		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 2011 report.				\$	22,260	1	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				2011	\$	21,932	2
3. Under or (over) accrual (line 2 minus line 1).				\$		(328)	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)				\$		22,596	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.				Home Office Allocation			
TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$		446	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$		22,714	7
Real Estate Tax History:							
Real Estate Tax Bill for Calendar Year:		2007	18,975	8			
		2008	19,815	9			
		2009	20,752	10			
		2010	21,603	11			
		2011	21,932	12			
Accrual based on prior year tax bill.							

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION \$		16

NOTES:

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

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME
Newman Rehabilitation & Health Care Center

COUNTY
Douglas

FACILITY IDPH LICENSE NUMBER
0047506

CONTACT PERSON REGARDING THIS REPORT
Mark Petersen

TELEPHONE
(309)691-8113
FAX #:
(309) 691-8622

A.
Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2011.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	07-06-31-400-012	Long-Term Care Facility	\$ 21,932.44	\$ 21,932.44
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 21,932.44	\$ 21,932.44

B.
Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:	20,206	B. General Construction Type:	Exterior Brick	Frame Protected	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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	20,206	2005	\$	1
2					2
3	TOTALS	20,206		\$	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					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Sidewalks		2006		5,535		8	692	692	4,498
10	2 Rooftop A/C		2006		11,726		5	1,173	1,173	12,899
11	Roof		2007		43,864		20	2,193	2,193	12,062
12	Water Heater		2007		25,462		10	2,546	2,546	14,003
13	Rooftop Unit		2011		7,350		15	490	490	735
14	Rooftop Unit		2011		6,925		15	462	462	693
15	Sand Filter		2012		5,000		7	357	357	357
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	Land Improvements Booked					369			(369)	
31	Building Improvement Booked					5,326			(5,326)	
32										
33										
34	2012-Home Office Allocation-Land Improvements				755			48	48	
35	2012-Home Office Allocation-Building Improvements				8,090			194	194	
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)		\$114,707	\$5,695		\$8,155	\$2,460	\$45,247	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	\$27,436	\$4,203	\$2,876	\$ (1,327)	5-10 yrs.	\$7,986	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	9,049					9,049	73
74	Home Office Allocation			2,859	2,859			74
75	TOTALS	\$36,485	\$4,203	\$5,735	\$1,532		\$17,035	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$151,192	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$9,898	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$13,890	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$3,992	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$62,282	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:Springwood Associates Limited Partnership
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:		60	12/1/1992	\$203,350	10	N/A	3
4	Additions							4
5								5
6								6
7	TOTAL		60		\$203,350			7

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☐ NOTerms: *

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: \$12,187Description: 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	2006 Ford E250	\$578.17	\$6,938	17
18					18
19					19
20					20
21	TOTAL		\$578.17	\$6,938	21

10. Effective dates of current rental agreement:

Beginning12/1/1992

Ending10/1/18

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

	Fiscal Year Ending	Annual Rent
12.	/2013	\$202,794
13.	/2014	\$202,794
14.	/2015	\$202,794

* 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.

Newman Rehabilitation & Health Care Center
0047506
Period Beginning 1/1/2012
Period End 12/31/2012

Schedule 14A

XII. Rental Costs
B. Equipment
16. Description of rental amount for movable equipment

Medical Equipment	\$ 3,770
Dishwasher	731
Laundry Equipment	-
Copier	7,195
Home Office Allocation	491
	<u>12,187</u>

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

		1	2	3	4
		Facility			
		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)	\$			

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.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	6,372	\$ 95,576	\$	6,372	\$ 95,576	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		345	5,180		345	5,180	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		8,580	128,693		8,580	128,693	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				52,095		52,095	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Respiratory Therapy	10A(3)			7	110		7	110	13
14	TOTAL			\$	15,304	\$ 229,559	\$ 52,095	15,304	\$ 281,654	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.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,995,427	\$ 1,995,427	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 5,000)	673,656	673,656	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	23,605	23,605	6
7	Other Prepaid Expenses	7,621	7,621	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Security Deposit	45,797	45,797	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,746,106	\$ 2,746,106	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	5,535		13
14	Buildings, at Historical Cost		8,090	14
15	Leasehold Improvements, at Historical Cost	100,327	106,617	15
16	Equipment, at Historical Cost	36,485	36,485	16
17	Accumulated Depreciation (book methods)	(72,975)	(62,282)	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)	\$ 69,372	\$ 88,910	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,815,478	\$ 2,835,016	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 631,696	\$ 631,696	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	18,613	18,613	30
31	Accrued Taxes Payable (excluding real estate taxes)	15,693	15,693	31
32	Accrued Real Estate Taxes(Sch.IX-B)	22,596	22,596	32
33	Accrued Interest Payable	774	774	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	15,699	15,699	36
37	Accrued Management Fees	143,150	143,150	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 848,221	\$ 848,221	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	280,244	280,244	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 280,244	\$ 280,244	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,128,465	\$ 1,128,465	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,687,013	\$ 1,706,551	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,815,478	\$ 2,835,016	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,407,430	1
2	Restatements (describe):		2
3	Rounding		3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,407,430	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	279,583	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)	\$ 279,583	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)	\$ 1,687,013	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Newman Rehabilitation & Health Care Center# 0047506Report Period Beginning: 1/1/2012Ending: 12/31/2012

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		2
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,649,604	1
2	Discounts and Allowances for all Levels	(227,879)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,421,725	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	348,230	6
7	Oxygen	2,194	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 350,424	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	1,793	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	114,702	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	6,220	20
21	Other Medical Services	2,080	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 124,795	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	932	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 932	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	166	28
28a	Transportation Revenue	427	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 593	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,898,469	30

	1		2
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	452,778	31
32	Health Care	1,088,318	32
33	General Administration	544,630	33
	B. Capital Expense		
34	Ownership	277,456	34
	C. Ancillary Expense		
35	Special Cost Centers	69,393	35
36	Provider Participation Fee	186,311	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,618,886	40
41	Income before Income Taxes (line 30 minus line 40)**	279,583	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 279,583	43

	1		2
	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,352,154	44
45	Private Pay - Net Inpatient Revenue	774,250	45
46	Medicare - Net Inpatient Revenue	298,604	46
47	Other-(specify) <u>Charity Therapy Allowance</u>	(1,480)	47
48	Other-(specify) <u>Insurance Contractual Allowance</u>	(1,803)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,421,725	49

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

** Does this agree with taxable income (loss) per Federal Income

Tax Return? No If not, please attach a reconciliation.

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

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

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,080	2,192	\$ 62,777	\$ 28.64	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,556	2,557	60,492	23.66	3
4	Licensed Practical Nurses	10,384	11,035	217,372	19.70	4
5	CNAs & Orderlies	30,845	31,921	324,011	10.15	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,913	2,093	27,291	13.04	9
10	Activity Assistants					10
11	Social Service Workers	2,080	2,080	26,402	12.69	11
12	Dietician					12
13	Food Service Supervisor	1,899	2,091	31,803	15.21	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,799	9,044	76,452	8.45	15
16	Dishwashers					16
17	Maintenance Workers	1,922	2,098	38,080	18.15	17
18	Housekeepers	8,672	9,325	87,842	9.42	18
19	Laundry	1,800	1,962	16,962	8.65	19
20	Administrator	2,080	2,080	57,519	27.65	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,521	1,777	25,653	14.44	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,988	2,144	27,218	12.69	31
32	Other Health Care Care Plan Coord	880	879	19,321	21.98	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	79,419	83,278	\$ 1,099,195 *	\$ 13.20	34

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	11,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,381	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)		\$ 14,381		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	11	\$ 316	L10, C3	50
51	Licensed Practical Nurses	41	1,084	L10, C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	52	\$ 1,399		53

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

** See instructions.

Newman Rehabilitation & Health Care Center
0047506
Period Beginning 1/1/2011
Period End 12/31/2011

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	-	-		#DIV/0!
Restorative Aide				#DIV/0!
Certified Medical Technician				#DIV/0!
Alzheimer's Coordinator				#DIV/0!
Restorative Nurse				#DIV/0!
Transportation	-	-	-	#DIV/0!
Marketing				#DIV/0!
TOTAL				

STATE OF ILLINOIS

Facility Name & ID Number

Newman Rehabilitation & Health Care Center

0047506

Report Period Beginning:

1/1/2012

Page 21

Ending:

12/31/2012

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description	Amount	Description	Amount				
Michael Boner	Administrator	0	\$ 17,311	Workers' Compensation Insurance	\$ 23,362	IDPH License Fee	\$ 1,990				
Patricia Galindo	Administrator	0	40,208	Unemployment Compensation Insurance	28,511	Advertising: Employee Recruitment	384				
				FICA Taxes	80,511	Health Care Worker Background Check					
				Employee Health Insurance	19,648	(Indicate # of checks performed)					
				Employee Meals		Patient Background Checks	50	508			
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits		908			
				Employee Relations	547						
				Employee Retirement	1,375	Home Office Allocation		279			
TOTAL (agree to Schedule V, line 17, col. 1)											
(List each licensed administrator separately.)			\$ 57,519								
B. Administrative - Other											
Description			Amount								
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 187,000								
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 187,000								
(Attach a copy of any management service agreement)											
C. Professional Services				E. Schedule of Non-Cash Compensation Paid			G. Schedule of Travel and Seminar**				
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount			
E-Health Data Solutions	Computer Services		\$ 1,460				Out-of-State Travel	\$			
Allscripts	Computer Services		1,200								
Honkamp Krueger & Co.	Accounting Services		569	N/A							
Cellular One	Computer Services		242				In-State Travel				
AKF Reporters	Reversal of 2011 Invoice		(1,262)								
Sorling, Northrup	Legal Services		1,570								
Estate of Beulah Potter	Legal Settlement		117,568								
Betsy Ridenour	Reversal of 2011 Invoice		(1,021)				Seminar Expense				
Frontier	Computer Services		674								
							Home Office Allocation	6			
							Entertainment Expense	()			
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V,				
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 121,000				line 24, col. 8)	\$ 6			

* Attach copy of IMRF notifications

**See instructions.

Newman Rehabilitation & Health Care Center
0047506
Period Beginning 1/1/2012
Period End 12/31/2012

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		121,000
Home Office Allocation		
Sorling Northrup	Legal	54
Ginoli & Company	Accountants	1,935
Miscellaneous	Computer Services	46
Nebo Systems	Computer Services	1
Advanced Answers on Demand	Computer Services	2628
Access 2 Go	Computer Services	111
Stratus Networks	Computer Services	109
Kemper Technology	Computer Services	179
CCH	Computer Services	9
Medifax	Computer Services	21
Vision Share/Ability Network	Computer Services	200
Barracuda	Computer Services	7
CIAN	Computer Services	55
Comcast	Computer Services	17
Postini	Computer Services	170
Optimizer Systems	Other Prof Fees	27
Marotta Gund Budd & Dzera	Other Prof Fees	67412
David Budde	Other Prof Fees	10
Courtney Bourban	Other Prof Fees	150
All Scripts	Other Prof Fees	459
Heritage Enterprises	Other Prof Fees	11
Miscellaneous Vendors	Other Prof Fees	3
Total (agree to Schedule V, line 19, column 8)		<u>194,614</u>

Newman Rehabilitation & Health Care Center
0047506
Period Beginning 1/1/2012
Period End 12/31/2012

Schedule 21B

XIX. SUPPORT SCHEDULE
Legal Fees

Facility

Vendor/Payee	Invoice Total	Allocation %	Total
Estate of Beulah Potter and Sutterfield Law Offices	117,568.00	100%	117,568
Sorling, Northrup, Hanna, Cullen & Cochran	183.00	100%	183
Sorling, Northrup, Hanna, Cullen & Cochran	966.00	100%	966
Sorling, Northrup, Hanna, Cullen & Cochran	105.00	100%	105
Sorling, Northrup, Hanna, Cullen & Cochran	210.00	100%	210
Sorling, Northrup, Hanna, Cullen & Cochran	105.00	100%	105
AKF Reporters, Inc	(1,262.00)	100%	(1,262)
Betsy Ridenour	(1,020.00)	100%	(1,020)
Home Office Allocation			
Sorling Northrup	5,053	1.07%	54
			-
			-
			-
			-
Total Legal Fees			<u><u>116,909</u></u>

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

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

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. \$ 10,047 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. \$ 186,311
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. \$ 1,793
- (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. \$ 427
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? Adequate records have been maintained.
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli & Company
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

RECONCILIATION REPORT

Template

06:29 PM

6/13/2013

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB- SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB- SCHED.	LINE NO.	COL. NO.
Adjustment Detail	32,858	equal to	32,858	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	70,911	equal to	70,911	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	22,714	equal to	22,714	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	0	equal to	0	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	13,890	equal to	13,890	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	203,350	equal to	203,350	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	19,125	equal to	19,125	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	229,559	equal to	229,559	0	O.K.	Pg16 Z12+Z14..	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv.- Supplies	52,095	equal to	52,095	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	452,778	equal to	452,778	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	1,088,318	equal to	1,088,318	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	544,630	equal to	544,630	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	277,456	equal to	277,456	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	69,393	equal to	69,393	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24++	N/A	38to41+43	4
Income Stat. Prov. Partic.	186,311	equal to	186,311	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	711,191	equal to	711,191	0	O.K.	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	27,291	equal to	27,291	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	26,402	equal to	26,402	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	108,255	equal to	108,255	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	38,080	equal to	38,080	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	87,842	equal to	87,842	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	16,962	equal to	16,962	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	57,519	equal to		0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	25,653	equal to	25,653	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	1,099,195	equal to	1,041,676	57,519	FAILED	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	0	< or = to		0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	11,000	< or = to	11,000	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	4,780	< or = to	-2,835	7,615	FAILED	Pg20 X14..X16+	B. & C.	7to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to	295	-295	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	0	< or = to		0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	57,519	equal to		0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	187,000	equal to	187,000	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3

Supp. Sched.- Prof. Serv.	121,000	equal to	121,000	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	153,954	equal to	153,954	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	4,069	equal to	4,069	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	6	equal to	6	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	186,311	equal to	186,311	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	0	< or = to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	1,517	equal to	1,759	-242	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	52,583	equal to	52,583	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4I	B.	14	8
Total loan balance	280,244	equal to	280,244	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	22,596	equal to	22,596	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	0	equal to		0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	114,707	equal to	114,707	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	36,485	equal to	36,485	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	62,282	equal to	62,282	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	1,687,013	equal to	1,687,013	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	279,583	equal to	279,583	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..J3	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	2,815,478	equal to	2,815,478	0	O.K.	Pg17:H41	N/A	25	1	Pg17 S41	N/A	48	1

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Adjusted Total
1. Dietary	108,255	9,720	0	117,975	0	117,975	3,149	121,124
2. Food Purchase	0	88,296	0	88,296	0	88,296	-1,687	86,609
3. Housekeeping	87,842	15,057	0	102,899	0	102,899	24	102,923
4. Laundry	16,962	17,266	0	34,228	0	34,228	4	34,232
5. Heat and Other Utilities	0	0	45,472	45,472	0	45,472	248	45,720
6. Maintenance	38,080	6,639	19,189	63,908	0	63,908	1,747	65,655
7. Other (specify)*	0	0	0	0	0	0	419	419
8. Total General Services	251,139	136,978	64,661	452,778	0	452,778	3,904	456,682
9. Medical Director	0	0	11,000	11,000	0	11,000	0	11,000
10. Nursing & Medical Records	711,191	85,388	-2,835	793,744	0	793,744	30	793,774
10a. Therapy	0	0	229,559	229,559	0	229,559	0	229,559
11. Activities	27,291	27	295	27,613	0	27,613	-427	27,186
12. Social Services	26,402	0	0	26,402	0	26,402	0	26,402
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	764,884	85,415	238,019	1,088,318	0	1,088,318	-397	1,087,921
17. Administrative	0	0	187,000	187,000	0	187,000	-129,481	57,519
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	121,000	121,000	0	121,000	73,614	194,614
20. Fees, Subscriptions & Promotion	0	0	3,790	3,790	0	3,790	279	4,069
21. Clerical & General Office	25,653	5,033	14,325	45,011	0	45,011	36,437	81,448
22. Employee Benefits & Payroll	0	0	153,954	153,954	0	153,954	0	153,954
23. Inservice Training & Education	0	0	0	0	0	0	59	59
24. Travel and Seminar	0	0	0	0	0	0	6	6
25. Other Admin. Staff Trans	0	0	7,937	7,937	0	7,937	4,120	12,057
26. Insurance-Prop.Liab.Malpractice	0	0	25,938	25,938	0	25,938	673	26,611
27. Other (specify)*	0	0	0	0	0	0	8,408	8,408
28. Total General Adminis	25,653	5,033	513,944	544,630	0	544,630	-5,885	538,745
29. Total General Administrative	1,041,676	227,426	816,624	2,085,726	0	2,085,726	-2,378	2,083,348
30. Depreciation	0	0	9,898	9,898	0	9,898	3,992	13,890
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	23,306	23,306	0	23,306	47,605	70,911
33. Real Estate	0	0	22,268	22,268	0	22,268	446	22,714

34. Rent - Facility & Grounds	0	0	203,350	203,350	0	203,350	0	203,350
35. Rent - Equipment & Vehicles	0	0	18,634	18,634	0	18,634	491	19,125
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	277,456	277,456	0	277,456	52,534	329,990
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	52,095	0	52,095	0	52,095	0	52,095
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	186,311	186,311	0	186,311	0	186,311
43. Other (specify):*	0	781	16,517	17,298	0	17,298	-17,298	0
44. Total Special Cost Ce	0	52,876	202,828	255,704	0	255,704	-17,298	238,406
45. Grand Total	1,041,676	280,302	1,296,908	2,618,886	0	2,618,886	32,858	2,651,744

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	1,995,427	1,995,427
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	673,656	673,656
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	23,605	23,605
7. Other Prepaid Expenses	7,621	7,621
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	45,797	45,797
10. Total current assets	2,746,106	2,746,106
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	5,535	0
14. Buildings, at Historical Cost	0	8,090
15. Leasehold Improvements, Historical Cost	100,327	106,617
16. Equipment, at Historical Cost	36,485	36,485
17. Accumulated Depreciation (book methods)	-72,975	-62,282
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	0
24. Total Long-Term Assets	69,372	88,910
25. Total Assets	2,815,478	2,835,016
CURRENT LIABILITIES		
26. Accounts Payable	631,696	631,696
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	18,613	18,613
31. Accrued Taxes Payable	15,693	15,693
32. Accrued Real Estate Taxes	22,596	22,596
33. Accrued Interest Payable	774	774
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	15,699	15,699

37. Other Current Liabilities (specify):	143,150	143,150
38. Total Current Liabilities	848,221	848,221
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	280,244	280,244
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	280,244	280,244
46.Total Liabilities	1,128,465	1,128,465
47.Total Equity	1,687,013	1,706,551
48.Total Liabilities and Equity	2,815,478	2,835,016

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	2,649,604
2. Discounts and Allowances for all Levels	-227,879
Subtotal - Inpatient Care	2,421,725
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	348,230
7. Oxygen	2,194
Subtotal - Anciliary Revenue	350,424
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	1,793
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	114,702
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiologyand X-Ray	6,220
21. Other Medical Services	2,080
22. Laundry	0
Subtotal - Other Operating Revenue	124,795
24. Contributions	0
25. Interest and Other Investments Income	932
Subtotal - Non-Operating Revenue	932
27. Other Revenue (specify):	0
28. Other Revenue (specify):	593
Subtotal - Other Revenue	593
30. Total Revenue	2,898,469
31. General Services	456,670
32. Health Care	1,067,311
33. General Administration	570,153
34. Ownership	273,411

35. Special Cost Centers	98,483
35. Provider Participation Fee	32,850
37. Other	0
40. Total Expenses	2,498,878
41. Income Before Income Taxes	399,591
42. Income Taxes	0
43. Net Income or Loss for the Year	399,591

Enter Cost Center Expenses

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

6/13/201306:29:19 PM

HSA Number:

4

Name:

Newman Rehabilitation & Health Care Center

Cost report period

From:

1/1/2012

To:

12/31/2012

Base Number:

444

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

N

Licensed bed days:

21,900

Occupancy:

17,298

Pct. of occupancy:

78.99%

Illinois Public Aid Support Rate:

\$

Genl Services Salary/Wage:

251,139

Col 1, Line 8 ---Audit Adj:

Genl Admin Salary/Wage:

25,653

Col 1, Line 28 ---Audit Adj:

Total Salary Wage:

1,041,676

Col 1, Line 44 ---Audit Adj:

Employee Benefits:

153,954

Col 8, Line 22 ---Audit Adj:

Total General Services:

456,682

Col 8, Line 8 ---Audit Adj:

Total General Admin:

538,745

Col 8, Line 28 ---Audit Adj:

Instructions and Calculation Steps

STEP I

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

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

A.

General Services

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

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

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

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

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

B.

General Administration

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

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

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

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

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

HFS 3745 (N-4-99)

IL478-2471

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

STEP II Adjust Support Service Costs for Inflation

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

A. Base Number Calculation

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

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

Sum of the three lines
Subtract from the sum

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

B. Select the Appropriate Inflation Multipliers

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

General Services Multiplier:
General Administration Multiplier:

C. Apply Inflation Multipliers to Update Cost

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

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

Updated General Services Cost

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

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

Updated General Services Cost

3 Total Updated Support Costs (1 + 2)

STEP III Convert Total Updated Support Costs (C-3) to Per Diem Costs

Use one of the two procedures below to compute per diem costs.

CALCULATED PER DIEM SUPPORT COSTS

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

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

Support Costs per Diem

OR

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

Licensed Bed Days
Multiplied by

Minus total Patient Days

One-third of difference

Plus Total Patient Days

Adjusted Occupancy

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

Support Costs Per Diem

STEP IV Calculate Support Rate

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

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

75 Percentile Rate for your HSA
Minus Support Costs Per Diem

Difference

Multiply the Difference by

One-Half of the Difference

Plus Support Costs Per Diem

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

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

75 Percentile Rate for your HSA
Minus Support Costs Per Diem

Difference

Multiply the Difference by

One-Half of the Difference

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

Enter the Lower of the Two Amounts

Plus Support Costs Per Diem

Support Rate if support costs less than 35th percentile

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

75th Percentile is

35th Percentile is

Table I
Inflation Multipliers

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

\$251,139
\$1,041,676
24.1091%
\$153,954
\$37,117
\$456,682
\$493,799

\$25,653
\$1,041,676
2.4627%

Table II
SupportRate percentiles by HSA

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

Table II (For ICF
SupportRate per

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

\$153,954
\$3,791
\$538,745
\$153,954
\$388,582

6.5
0.526315789
1344
1351.026316
907.00
444

1
1

\$493,799
1

\$493,799

\$388,582
<u>1</u>
\$388,582
<u>\$882,381</u>

\$48.16

\$882,381
<u>17,298</u>
<u>\$51.01</u>

21,900
<u>0.93</u>
20,367
<u>17,298</u>
3,069
1,023
<u>17,298</u>
<u>18,321</u>

\$882,381
18321
\$48.16

\$47.44
\$48.16
-\$0.72
0.5
-\$0.36
\$48.16
47.8

\$47.44
\$48.16
-\$0.72

0.5
<u>-\$0.36</u>
3.795
<u>-\$0.360</u>
<u>\$48.16</u>
<u>\$47.80</u>
<u>\$47.44</u>
\$47.44
\$39.95

7/DD 16 Facilities)
centiles by HSA
Not updated with current figures

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