

		FOR BHF USE					

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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: <u>0050849</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Roseville Rehabilitation & Health Care</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2012</u> to <u>12/31/2012</u> 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.																							
Address: <u>145 South Chamberlain St.</u> <u>Roseville</u> <u>61473</u>																									
Number City Zip Code																									
County: <u>Warren</u>																									
Telephone Number: <u>(309) 426-2134</u> Fax # <u>(309) 426-2445</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>Mark B. Petersen</u></td></tr><tr><td>(Title) <u>Chief Executive Officer</u></td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) _____</td></tr><tr><td>(Telephone) <u>()</u> Fax # <u>()</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Mark B. Petersen</u>	(Title) <u>Chief Executive Officer</u>	(Signed) _____	Paid Preparer	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) _____	(Telephone) <u>()</u> Fax # <u>()</u>												
Officer or Administrator of Provider	(Signed) _____																								
	(Type or Print Name) <u>Mark B. Petersen</u>																								
	(Title) <u>Chief Executive Officer</u>																								
	(Signed) _____																								
Paid Preparer	(Date) _____																								
	(Print Name and Title) _____																								
	(Firm Name & Address) _____																								
	(Telephone) <u>()</u> Fax # <u>()</u>																								
Date of Initial License for Current Owners: <u>4/1/2010</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td>_____</td></tr><tr><td></td><td>☐ Other _____</td><td>_____</td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☒ Limited Liability Co.	_____		☐ Trust	_____		☐ Other _____	_____
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	☒ Limited Liability Co.	_____																							
	☐ Trust	_____																							
	☐ Other _____	_____																							
In the event there are further questions about this report, please contact:		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																							
Name: <u>Mike Kocher</u> Telephone Number: <u>(309) 689-5850</u>																									
Email Address: _____																									

Facility Name & ID Number Roseville Rehabilitation & Health Care# 0050849 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>99</u>	Skilled (SNF)	<u>99</u>	<u>36,135</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>99</u>	TOTALS	<u>99</u>	<u>36,135</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>14,280</u>	<u>6,535</u>	<u>1,607</u>	<u>22,422</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>14,280</u>	<u>6,535</u>	<u>1,607</u>	<u>22,422</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 62.05%

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

4/1/2010

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

YES

☒Date 4/1/2010

NO

☐

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

YES

☒

NO

☐

If YES, enter number

of beds certified

99

and days of care provided

1,433Medicare Intermediary Cahaba

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	159,559	8,854		168,413		168,413	4,082	172,495		1
2	Food Purchase		122,924		122,924		122,924	(8,621)	114,303		2
3	Housekeeping	106,500	15,764		122,264		122,264	31	122,295		3
4	Laundry	35,228	9,248		44,476		44,476	6	44,482		4
5	Heat and Other Utilities			69,752	69,752		69,752	322	70,074		5
6	Maintenance	40,037	15,609	21,810	77,456		77,456	2,264	79,720		6
7	Other (specify):* Home Off. Ben. All.							544	544		7
8	TOTAL General Services	341,324	172,399	91,562	605,285		605,285	(1,372)	603,913		8
	B. Health Care and Programs										
9	Medical Director			7,200	7,200		7,200		7,200		9
10	Nursing and Medical Records	804,907	61,528	3,062	869,497		869,497	(2,808)	866,689		10
10a	Therapy			233,482	233,482		233,482		233,482		10a
11	Activities	60,987	845	385	62,217		62,217	(9,967)	52,250		11
12	Social Services	21,418			21,418		21,418		21,418		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.										15
16	TOTAL Health Care and Programs	887,312	62,373	244,129	1,193,814		1,193,814	(12,775)	1,181,039		16
	C. General Administration										
17	Administrative			320,200	320,200		320,200	(242,607)	77,593		17
18	Directors Fees										18
19	Professional Services			18,170	18,170		18,170	22,049	40,219		19
20	Dues, Fees, Subscriptions & Promotions			7,366	7,366		7,366	(1,838)	5,528		20
21	Clerical & General Office Expenses	20,668	14,188	23,980	58,836		58,836	50,366	109,202		21
22	Employee Benefits & Payroll Taxes			183,630	183,630		183,630		183,630		22
23	Inservice Training & Education			1,090	1,090		1,090	77	1,167		23
24	Travel and Seminar							8	8		24
25	Other Admin. Staff Transportation			45,285	45,285		45,285	5,294	50,579		25
26	Insurance-Prop.Liab.Malpractice			48,490	48,490		48,490	22,795	71,285		26
27	Other (specify):* Home Off. Ben. All.							10,900	10,900		27
28	TOTAL General Administration	20,668	14,188	648,211	683,067		683,067	(132,956)	550,111		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,249,304	248,960	983,902	2,482,166		2,482,166	(147,103)	2,335,063		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			4,700	4,700		4,700	183,129	187,829			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							228,944	228,944			32
33	Real Estate Taxes							118,401	118,401			33
34	Rent-Facility & Grounds			669,236	669,236		669,236	(669,236)				34
35	Rent-Equipment & Vehicles			6,489	6,489		6,489	575	7,064			35
36	Other (specify):*											36
37	TOTAL Ownership			680,425	680,425		680,425	(138,187)	542,238			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		49,659		49,659		49,659		49,659			39
40	Barber and Beauty Shops	9,843			9,843		9,843	(8,473)	1,370			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			267,464	267,464		267,464		267,464			42
43	Other (specify):* Non-allowable Costs	32,134	15,822	100,962	148,918		148,918	(148,918)				43
44	TOTAL Special Cost Centers	41,977	65,481	368,426	475,884		475,884	(157,391)	318,493			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,291,281	314,441	2,032,753	3,638,475		3,638,475	(442,681)	3,195,794			45

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

		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	(8,759)	2		4
5	Telephone, TV & Radio in Resident Rooms	(10,284)	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	(26,454)	30		9
10	Interest and Other Investment Income	(2,364)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(582)	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	(25,558)	43		18
19	Entertainment				19
20	Contributions	(10,286)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(36,345)	43		24
25	Fund Raising, Advertising and Promotional	(58,568)	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	(30,908)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (210,108)		\$	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)	(232,573)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (232,573)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (442,681)		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
Roseville Rehabilitation & Health Care

Page 5A

ID# 0050849
Report Period Beginning: 1/1/2012
Ending: 12/31/2012

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (2,872)	43	1
2	X-Rays-Part A	(1,720)	43	2
3	Offset Vending Machine Expense	(75)	43	3
4	Offset Miscellaneous Office Supplies Revenue	(174)	21	4
5	Offset Transportation Revenue	(9,967)	11	5
6	Offset Miscellaneous Nursing Supplies Revenue	(2,847)	10	6
7	Special Events	33	43	7
8	Offset Barber and Beauty Revenue	(8,473)	40	8
9	Pet Expense	(829)	43	9
10	Offset Chamber of Commerce Dues	(2,152)	20	10
11	Disallowed IDES Interest Expense	(1,832)	32	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
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26				26
27				27
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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	(30,908)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Roseville Rehabilitation & Health Care # 0050849 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	4,082	0	0	0	0	0	0	0	0	0	4,082	1
2	Food Purchase	(8,759)	138	0	0	0	0	0	0	0	0	0	(8,621)	2
3	Housekeeping	0	31	0	0	0	0	0	0	0	0	0	31	3
4	Laundry	0	6	0	0	0	0	0	0	0	0	0	6	4
5	Heat and Other Utilities	0	322	0	0	0	0	0	0	0	0	0	322	5
6	Maintenance	0	2,264	0	0	0	0	0	0	0	0	0	2,264	6
7	Other (specify):*	0	544	0	0	0	0	0	0	0	0	0	544	7
8	TOTAL General Services	(8,759)	7,387	0	0	0	0	0	0	0	0	0	(1,372)	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	(2,847)	39	0	0	0	0	0	0	0	0	0	(2,808)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(9,967)	0	0	0	0	0	0	0	0	0	0	(9,967)	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	(12,814)	39	0	0	0	0	0	0	0	0	0	(12,775)	16
	C. General Administration													
17	Administrative	0	(242,607)	0	0	0	0	0	0	0	0	0	(242,607)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	22,049	0	0	0	0	0	0	0	0	0	22,049	19
20	Fees, Subscriptions & Promotions	(2,152)	0	314	0	0	0	0	0	0	0	0	(1,838)	20
21	Clerical & General Office Expenses	(174)	0	46,204	4,336	0	0	0	0	0	0	0	50,366	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	77	0	0	0	0	0	0	0	0	77	23
24	Travel and Seminar	0	0	8	0	0	0	0	0	0	0	0	8	24
25	Other Admin. Staff Transportation	0	0	5,294	0	0	0	0	0	0	0	0	5,294	25
26	Insurance-Prop.Liab.Malpractice	0	0	873	21,922	0	0	0	0	0	0	0	22,795	26
27	Other (specify):*	0	0	10,900	0	0	0	0	0	0	0	0	10,900	27
28	TOTAL General Administration	(2,326)	(220,558)	63,670	26,258	0	0	0	0	0	0	0	(132,956)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(23,899)	(213,132)	63,670	26,258	0	0	0	0	0	0	0	(147,103)	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	(26,454)	0	3,922	205,661	0	0	0	0	0	0	0	183,129	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,196)	0	7,797	223,511	0	0	0	0	0	0	0	227,112	32
33	Real Estate Taxes	0	0	578	117,823	0	0	0	0	0	0	0	118,401	33
34	Rent-Facility & Grounds	0	0	0	(669,236)	0	0	0	0	0	0	0	(669,236)	34
35	Rent-Equipment & Vehicles	0	0	575	0	0	0	0	0	0	0	0	575	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(30,650)	0	12,872	(122,241)	0	0	0	0	0	0	0	(140,019)	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	(8,473)	0	0	0	0	0	0	0	0	0	0	(8,473)	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):*	(147,086)	0	0	0	0	0	0	0	0	0	0	(147,086)	43
44	TOTAL Special Cost Centers	(155,559)	0	0	0	0	0	0	0	0	0	0	(155,559)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(210,108)	(213,132)	76,542	(95,983)	0	0	0	0	0	0	0	(442,681)	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%	\$ 4,082	\$ 4,082	1
2	V	2	Food		Petersen Health Care, Inc.	100.00%	138	138	2
3	V	3	Housekeeping		Petersen Health Care, Inc.	100.00%	31	31	3
4	V	4	Laundry		Petersen Health Care, Inc.	100.00%	6	6	4
5	V	5	Utilities		Petersen Health Care, Inc.	100.00%	322	322	5
6	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	2,264	2,264	6
7	V	7	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	544	544	7
8	V	10	Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	39	39	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	320,200	Petersen Health Care, Inc.	100.00%	77,593	(242,607)	11
12	V	19	Professional Services		Petersen Health Care, Inc.	100.00%	22,049	22,049	12
13	V								13
14	Total			\$ 320,200			\$ 107,068	\$ * (213,132)	14

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

VII. RELATED PARTIES (continued)

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

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	20	Dues, Fees, Subs & Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 314	\$	314
16	V	21	Clerical and General Office		Petersen Health Care, Inc.	100.00%	46,204		46,204
17	V	23	Inservice Training & Education		Petersen Health Care, Inc.	100.00%	77		77
18	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	8		8
19	V	25	Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	5,294		5,294
20	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	873		873
21	V	27	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	10,900		10,900
22	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	3,922		3,922
23	V	32	Interest		Petersen Health Care, Inc.	100.00%	7,797		7,797
24	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	578		578
25	V	34	Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0		
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	575		575
27	V								
28	V								
29	V								
30	V								
31	V								
32	V								
33	V								
34	V								
35	V								
36	V								
37	V								
38	V								
39	Total			\$			\$ 76,542	\$ *	76,542

* 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	21	Clerical and General Office		Petersen Health Care-Roseville, LLC	100.00%	\$ 4,336	\$ 4,336	15
16	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care-Roseville, LLC	100.00%	21,922	21,922	16
17	V	30	Depreciation		Petersen Health Care-Roseville, LLC	100.00%	205,661	205,661	17
18	V	32	Amortization		Petersen Health Care-Roseville, LLC	100.00%	993	993	18
19	V	32	Interest		Petersen Health Care-Roseville, LLC	100.00%	222,518	222,518	19
20	V	33	Real Estate Taxes		Petersen Health Care-Roseville, LLC	100.00%	117,823	117,823	20
21	V	34	Rent-Facility and Grounds	669,236	Petersen Health Care-Roseville, LLC	100.00%		(669,236)	21
22	V					100.00%			22
23	V					100.00%			23
24	V					100.00%			24
25	V					100.00%			25
26	V					100.00%			26
27	V					100.00%			27
28	V					100.00%			28
29	V					100.00%			29
30	V					100.00%			30
31	V					100.00%			31
32	V					100.00%			32
33	V					100.00%			33
34	V					100.00%			34
35	V					100.00%			35
36	V					100.00%			36
37	V					100.00%			37
38	V					100.00%			38
39	Total			\$ 669,236			\$ 573,253	\$ * (95,983)	39

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

Facility Name & ID Number Roseville Rehabilitation & Health Care # 0050849 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

Roseville Rehabilitation & Health Care

0050849

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

Roseville Rehabilitation & Health Care

0050849

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 Roseville Rehabilitation & Health Care # 0050849 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 Roseville Rehabilitation & Health Care# 0050849

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	22,422	\$ 4,082	1
2	2	Food	Resident Days	1,569,393	74	9,632	0	22,422	138	2
3	3	Housekeeping	Resident Days	1,569,393	74	2,201	0	22,422	31	3
4	4	Laundry	Resident Days	1,569,393	74	397	0	22,422	6	4
5	5	Utilities	Resident Days	1,569,393	74	22,546	0	22,422	322	5
6	6	Maintenance	Resident Days	1,569,393	74	158,485	73,431	22,422	2,264	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,569,393	74	38,057	0	22,422	544	7
8	10	Nursing and Medical Records	Resident Days	1,569,393	74	2,750	0	22,422	39	8
9	10A	Therapy	Resident Days	1,569,393	74	0	0	22,422	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,569,393	74	0	0	22,422	0	10
11	17	Administrative	Resident Days	1,569,393	74	4,353,655	4,353,655	22,422	77,593	11
12	19	Professional Services	Resident Days	1,569,393	74	1,543,275	0	22,422	22,049	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,569,393	74	21,988	0	22,422	314	13
14	21	Clerical and General Office	Resident Days	1,569,393	74	3,233,970	2,816,787	22,422	46,204	14
15	23	Inservice Training & Education	Resident Days	1,569,393	74	5,397	0	22,422	77	15
16	24	Travel and Seminar	Resident Days	1,569,393	74	535	0	22,422	8	16
17	25	Other Admin. Staff Transport.	Resident Days	1,569,393	74	370,568	0	22,422	5,294	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,569,393	74	61,077	0	22,422	873	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,569,393	74	762,912	0	22,422	10,900	19
20	30	Depreciation	Resident Days	1,569,393	74	274,514	0	22,422	3,922	20
21	32	Interest	Resident Days	1,569,393	74	545,764	0	22,422	7,797	21
22	33	Real Estate Taxes	Resident Days	1,569,393	74	40,424	0	22,422	578	22
23	34	Rent-Facility and Grounds	Resident Days	1,569,393	74	0	0	22,422	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,569,393	74	40,223	0	22,422	575	24
25	TOTALS					\$ 11,774,077	\$ 7,528,087		\$ 183,610	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	Berkadia		X	Mortgage	\$44,073.00	4/1/10	\$ 3,998,669	\$ 3,580,477	3/31/39	0.0614	\$ 222,590	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$44,073.00		\$ 3,998,669	\$ 3,580,477			\$ 222,590	9	
	B. Non-Facility Related*												
10								Amortization of Loan Costs			993	10	
11								Interest Income Offset			(2,436)	11	
12								Home Office Allocation-PHC			7,797	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ 6,354	14	
15	TOTALS (line 9+line14)						\$ 3,998,669	\$ 3,580,477			\$ 228,944	15	

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

1. Real Estate Tax accrual used on 2011 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	122,000	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		\$	116,823	2
3. Under or (over) accrual (line 2 minus line 1).				\$	(5,177)	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	123,000	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.					578	
TOTAL REFUND \$ <u> </u> For <u> </u> Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	118,401	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

2007		8
2008		9
2009	70,570	10
2010	116,198	11
2011	116,823	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
Roseville Rehabilitation & Health Care

COUNTY
Warren

FACILITY IDPH LICENSE NUMBER
0050849

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)
Tax Index Number		Property Description	Total Tax	Tax Applicable to Nursing Home
1.	07-050-089-10	Land	\$ 505.88	\$ 505.88
2.	07-050-090-00	Nursing Facility	\$ 116,261.00	\$ 116,261.00
3.	07-050-107-00	Land	\$ 56.40	\$ 56.40
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
TOTALS			\$ 116,823.28	\$ 116,823.28

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: 29,817 B. General Construction Type: Exterior Brick Frame Block Number of Stories 1

C. Does the Operating Entity? [X] (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? [X] (a) Own the Equipment [] (b) Rent equipment from a Related Organization. [X] (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 [X] 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		2010	\$ 400,000	1
2					2
3	TOTALS			\$ 400,000	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	99		2010		\$ 2,998,669	\$	25	\$ 119,947	\$ 119,947	\$ 299,867
5										
6										
7										
8										
	Improvement Type**									
9										
10										
11										
12										
13										
14										
15										
16										
17										
18										
19										
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30	Land Improvements Booked									
31	Building Booked					119,947			(119,947)	
32	Building Improvement Booked									
33										
34	2012-Home Office Allocation-Land Improvements				979			63	63	
35	2012-Home Office Allocation-Building Improvements				10,486			251	251	
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 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 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)		\$ 3,010,134	\$ 119,947		\$ 120,261	\$ 314	\$ 299,867	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	\$600,000	\$85,715	\$60,000	\$(25,715)	10 yrs.	\$150,000	71
72	Current Year Purchases	3,196	266	160	(106)	10 yrs.	160	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			3,608	3,608			74
75	TOTALS	\$603,196	\$85,981	\$63,768	\$(22,213)		\$150,160	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	Facility	Van	2012	\$38,000	\$4,433	\$3,800	\$(633)	5 yrs.	\$3,800	76
77										77
78										78
79										79
80	TOTALS			\$38,000	\$4,433	\$3,800	\$(633)		\$3,800	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)	\$4,051,33081
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$210,36182
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$187,82983**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(22,532)84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$453,82785

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES
- ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			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
- ☐ NO
- Terms:
-
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☐ NO
16. Rental Amount for movable equipment: \$ 7,064
- Description:
- See Attached Schedule 14A
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

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

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

* 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.

Roseville Rehabilitation & Health Care
0047654
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	\$ 2,954
Dishwasher	-
Laundry Equipment	-
Copier	3,535
Home Office Allocation	575
	<u>7,064</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

ALLOCATION OF COSTS (d)

		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)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)										
		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	\$	6,927	\$ 103,910	\$	6,927	\$ 103,910	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		958	14,367		958	14,367	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		7,680	115,205		7,680	115,205	4
5	Physician Care		visits							5
6	Dental Care	39(2)	visits				110		110	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				49,549		49,549	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	15,565	\$ 233,482	\$ 49,659	15,565	\$ 283,141	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	\$ (19,561)	\$ (19,361)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 31,500)	487,760	487,760	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	29,915	30,237	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Security Deposits	1,096	1,096	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 499,210	\$ 499,732	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		400,000	13
14	Buildings, at Historical Cost		3,009,155	14
15	Leasehold Improvements, at Historical Cost		979	15
16	Equipment, at Historical Cost	41,196	641,196	16
17	Accumulated Depreciation (book methods)	(4,699)	(453,827)	17
18	Deferred Charges	(53,928)		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		272,407	21
22	Other Long-Term Assets (specify):		18,865	22
23	Other(specify): A/R-Prior Owner	26,994	26,994	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 9,563	\$ 3,915,769	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 508,773	\$ 4,415,501	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 535,584	\$ 535,584	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	40,368	40,368	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,169	2,169	31
32	Accrued Real Estate Taxes(Sch.IX-B)		123,000	32
33	Accrued Interest Payable		18,320	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	34,079	34,079	36
37	Accrued Management Fees	461,337	461,337	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,073,537	\$ 1,214,857	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,580,477	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	A/P Prior Owner	37,358	37,358	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 37,358	\$ 3,617,835	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,110,895	\$ 4,832,692	46
47	TOTAL EQUITY(page 18, line 24)	\$ (602,122)	\$ (417,191)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 508,773	\$ 4,415,501	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (110,264)	1
2	Restatements (describe):		2
3	Rounding	1	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (110,263)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(245,359)	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	(246,500)	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)	\$ (491,859)	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)	\$ (602,122)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Roseville Rehabilitation & Health Care# 0050849Report 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	\$ 3,080,921	1
2	Discounts and Allowances for all Levels	(190,227)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,890,694	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	371,872	6
7	Oxygen	160	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 372,032	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	8,307	13
14	Non-Patient Meals	8,759	14
15	Telephone, Television and Radio	3,375	15
16	Rental of Facility Space		16
17	Sale of Drugs	75,223	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	7,943	20
21	Other Medical Services	11,265	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 114,872	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,364	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,364	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous & Replacement Revenue	3,187	28
28a	Transportation Revenue	9,967	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 13,154	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,393,116	30

	1		2
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	605,285	31
32	Health Care	1,193,814	32
33	General Administration	683,067	33
	B. Capital Expense		
34	Ownership	680,425	34
	C. Ancillary Expense		
35	Special Cost Centers	208,420	35
36	Provider Participation Fee	267,464	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,638,475	40
41	Income before Income Taxes (line 30 minus line 40)**	(245,359)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (245,359)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,626,464	44
45	Private Pay - Net Inpatient Revenue	972,357	45
46	Medicare - Net Inpatient Revenue	295,419	46
47	Other-(specify) <u>Insurance Contractual Allowance</u>	(3,546)	47
48	Other-(specify) _____		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,890,694	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	2,080	\$ 55,991	\$ 26.92	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,337	3,407	65,504	19.23	3
4	Licensed Practical Nurses	13,686	14,510	240,155	16.55	4
5	CNAs & Orderlies	35,114	36,861	400,700	10.87	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,084	1,084	10,336	9.54	9
10	Activity Assistants	2,885	2,989	34,248	11.46	10
11	Social Service Workers	1,907	1,910	21,418	11.21	11
12	Dietician					12
13	Food Service Supervisor	1,852	1,908	21,590	11.32	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,014	14,649	137,969	9.42	15
16	Dishwashers					16
17	Maintenance Workers	2,284	2,950	40,037	13.57	17
18	Housekeepers	8,044	8,478	106,500	12.56	18
19	Laundry	2,987	3,195	35,228	11.03	19
20	Administrator	2,080	2,080	77,593	37.30	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,951	2,052	20,668	10.07	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) See PG20A	6,321	6,451	100,937	15.65	33
34	TOTAL (lines 1 - 33)	99,626	104,604	\$ 1,368,874 *	\$ 13.09	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	7,200	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,150	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)		\$ 10,350		49

C. CONTRACT NURSES

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

Roseville Rehabilitation & Health Care
0047654
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	2,080	2,080	42,557	20.46
Barber/Beauty Shop	853	926	9,843	10.63
Transportation	1,392	1,393	16,403	11.78
Marketing	1,996	2,052	32,134	15.66
TOTAL	6,321	6,451	100,937	

STATE OF ILLINOIS

Facility Name & ID Number

Roseville Rehabilitation & Health Care

0050849

Report Period Beginning:

1/1/2012

Page 21

Ending:

12/31/2012

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Ethel Logue	Administrator	0	\$ 77,593	Workers' Compensation Insurance	\$ 34,597	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance	21,822	Advertising: Employee Recruitment	1,624	
				FICA Taxes	95,993	Health Care Worker Background Check		
				Employee Health Insurance	17,983	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks	55 553	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	1,047	
				Employee Relations	13,235	Miscellaneous Dues & Subscriptions	2,152	
						Home Office Allocation	314	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 77,593					
B. Administrative - Other								
Description			Amount					
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 320,200			Less: Public Relations Expense	(2,152)	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 320,200	TOTAL (agree to Schedule V,	\$ 183,630	TOTAL (agree to Sch. V,	\$ 5,528	
(Attach a copy of any management service agreement)				line 22, col.8)		line 20, col. 8)		
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	
Frontier	Computer Services	\$ 1,108				Out-of-State Travel	\$	
Ginoli & Company	Accounting Services	4,020						
IL Secretary of State	Filing Fees	100	N/A					
Healthcare Resources	Legal Fees	5,000				In-State Travel		
Matt Weaver	Consultant Fees	3,500						
E-Health Data Solutions	Computer Services	4,442						
						Seminar Expense		
						Home Office Allocation	8	
						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.)			\$ 18,170			line 24, col. 8)	\$ 8	

* Attach copy of IMRF notifications

**See instructions.

Roseville Rehabilitation & Health Care
0047654

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)		18,170
Home Office Allocation		
Sorling Northrup	Legal	70
Ginoli & Company	Accountants	740
Miscellaneous	Computer Services	60
Nebo Systems	Computer Services	2
Advanced Answers on Demand	Computer Services	3407
Access 2 Go	Computer Services	143
Stratus Networks	Computer Services	141
Kemper Technology	Computer Services	233
CCH	Computer Services	12
Medifax	Computer Services	27
Vision Share/Ability Network	Computer Services	260
Barracuda	Computer Services	9
CIAN	Computer Services	71
Comcast	Computer Services	22
Postini	Computer Services	220
Optimizer Systems	Other Prof Fees	35
Marotta Gund Budd & Dzera	Other Prof Fees	15777
David Budde	Other Prof Fees	13
Courtney Bourban	Other Prof Fees	194
All Scripts	Other Prof Fees	595
Heritage Enterprises	Other Prof Fees	14
Miscellaneous Vendors	Other Prof Fees	4
Total (agree to Schedule V, line 19, column 8)		<u><u>40,219</u></u>

Roseville Rehabilitation & Health Care
0047654

Period Beginning 1/1/2011
Period End 12/31/2011

Schedule 21B

XIX. SUPPORT SCHEDULE
Legal Fees

Facility			
Vendor/Payee	Invoice Total	Allocation %	Total
Secretary of State	100.00	100%	100
Healthcare Resources International LLC	5,000.00	100%	5,000
Home Office Allocation			
Sorling Northrup	5,500.00	1.27%	70
			-
			-
			-
			-
Total Legal Fees			5,170

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. \$ 20,352 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. \$ 267,464
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. \$ 8,759
- (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. \$ 9,967
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? N/A
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.