

		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: 0046425

Facility Name: Sullivan Rehab & Health Care Center

Address: 11 Hawthorne Lane Sullivan 61951
Number City Zip Code

County: Moultrie

Telephone Number: (217) 728-4327 Fax # (217) 728-2263

HFS ID Number:

Date of Initial License for Current Owners: 12/01/1986

Type of Ownership:

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

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☒ "Sub-S" Corp.
☐ 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 Sullivan Rehab & Health Care Center# 0046425 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>123</u>	Skilled (SNF)	<u>123</u>	<u>44,895</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>123</u>	TOTALS	<u>123</u>	<u>44,895</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>11,937</u>	<u>3,627</u>	<u>2,308</u>	<u>17,872</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>11,937</u>	<u>3,627</u>	<u>2,308</u>	<u>17,872</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 39.81%

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)

Meals on Wheels

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 9/3/03

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

YES ☒ Date 9/3/03 NO ☐

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

YES ☒ NO ☐ If YES, enter number
of beds certified 123 and days of care provided 2,104Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/12 Fiscal 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 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	146,630	11,938		158,568		158,568	3,253	161,821			1
2	Food Purchase		109,449		109,449		109,449	(4,228)	105,221			2
3	Housekeeping	114,885	20,253		135,138		135,138	25	135,163			3
4	Laundry		4,140		4,140		4,140	5	4,145			4
5	Heat and Other Utilities			134,616	134,616		134,616	257	134,873			5
6	Maintenance	31,252	7,726	14,828	53,806		53,806	2,185	55,991			6
7	Other (specify):* Home Off. Ben. All.							433	433			7
8	TOTAL General Services	292,767	153,506	149,444	595,717		595,717	1,930	597,647			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	803,150	72,195	55,111	930,456		930,456	31	930,487			10
10a	Therapy	24,257	216	153,572	178,045		178,045		178,045			10a
11	Activities	22,319	764	7,423	30,506		30,506	(340)	30,166			11
12	Social Services	34,044	26		34,070		34,070		34,070			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Off. Ben. All.											15
16	TOTAL Health Care and Programs	883,770	73,201	228,106	1,185,077		1,185,077	(309)	1,184,768			16
	C. General Administration											
17	Administrative			207,800	207,800		207,800	(147,717)	60,083			17
18	Directors Fees											18
19	Professional Services			55,311	55,311		55,311	20,491	75,802			19
20	Dues, Fees, Subscriptions & Promotions			5,907	5,907		5,907	(43)	5,864			20
21	Clerical & General Office Expenses	26,655	4,831	8,337	39,823		39,823	38,614	78,437			21
22	Employee Benefits & Payroll Taxes			181,931	181,931		181,931	1,512	183,443			22
23	Inservice Training & Education							94	94			23
24	Travel and Seminar							6	6			24
25	Other Admin. Staff Transportation			5,001	5,001		5,001	4,492	9,493			25
26	Insurance-Prop.Liab.Malpractice			38,758	38,758		38,758	695	39,453			26
27	Other (specify):* Home Off. Ben. All.							8,687	8,687			27
28	TOTAL General Administration	26,655	4,831	503,045	534,531		534,531	(73,169)	461,362			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,203,192	231,538	880,595	2,315,325		2,315,325	(71,548)	2,243,777			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			53,194	53,194		53,194	9,283	62,477			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			75,034	75,034		75,034	17,847	92,881			32
33	Real Estate Taxes			47,780	47,780		47,780	460	48,240			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			26,663	26,663		26,663	513	27,176			35
36	Other (specify):*											36
37	TOTAL Ownership			202,671	202,671		202,671	28,103	230,774			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		116,425		116,425		116,425		116,425			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			229,845	229,845		229,845		229,845			42
43	Other (specify):* Non-allowable Costs		3,064	88,536	91,600		91,600	(91,600)				43
44	TOTAL Special Cost Centers		119,489	318,381	437,870		437,870	(91,600)	346,270			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	1,203,192	351,027	1,401,647	2,955,866		2,955,866	(135,045)	2,820,821			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	(4,338)	2		4
5	Telephone, TV & Radio in Resident Rooms	(10,872)	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	(3,956)	30		9
10	Interest and Other Investment Income	(1,333)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(271)	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	(21,972)	43		18
19	Entertainment				19
20	Contributions	(50)	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	(43,028)	43		24
25	Fund Raising, Advertising and Promotional	(7,051)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(9,832)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (102,703)		\$	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)	(32,342)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (32,342)		36
(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (135,045)		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
Sullivan Rehab & Health Care Center

Page 5A

ID# 0046425
Report Period Beginning: 1/1/2012
Ending: 12/31/2012

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (2,646)	43	1
2	X-Rays-Part A	(3,994)	43	2
3	Resident Flowers	(529)	43	3
4	Offset Miscellaneous Transportation Revenue	(340)	11	4
5	Offset Miscellaneous Office Supplies Revenue	(562)	21	5
6	Pet Expense	(1,187)	43	6
7	Offset Chamber of Commerce Dues	(309)	20	7
8	Medicare Withholding Penalty Interest	(265)	32	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	(9,832)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sullivan Rehab & Health Care Center

0046425

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	3,253	0	0	0	0	0	0	0	0	0	3,253	1
2	Food Purchase	(4,338)	110	0	0	0	0	0	0	0	0	0	(4,228)	2
3	Housekeeping	0	25	0	0	0	0	0	0	0	0	0	25	3
4	Laundry	0	5	0	0	0	0	0	0	0	0	0	5	4
5	Heat and Other Utilities	0	257	0	0	0	0	0	0	0	0	0	257	5
6	Maintenance	0	1,805	0	380	0	0	0	0	0	0	0	2,185	6
7	Other (specify):*	0	433	0	0	0	0	0	0	0	0	0	433	7
8	TOTAL General Services	(4,338)	5,888	0	380	0	0	0	0	0	0	0	1,930	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	31	0	0	0	0	0	0	0	0	0	31	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(340)	0	0	0	0	0	0	0	0	0	0	(340)	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	(340)	31	0	0	0	0	0	0	0	0	0	(309)	16
	C. General Administration													
17	Administrative	0	(147,717)	0	0	0	0	0	0	0	0	0	(147,717)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	17,574	0	2,917	0	0	0	0	0	0	0	20,491	19
20	Fees, Subscriptions & Promotions	(309)	0	250	16	0	0	0	0	0	0	0	(43)	20
21	Clerical & General Office Expenses	(562)	0	36,826	2,350	0	0	0	0	0	0	0	38,614	21
22	Employee Benefits & Payroll Taxes	0	0	0	1,512	0	0	0	0	0	0	0	1,512	22
23	Inservice Training & Education	0	0	61	33	0	0	0	0	0	0	0	94	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	4,220	272	0	0	0	0	0	0	0	4,492	25
26	Insurance-Prop.Liab.Malpractice	0	0	695	0	0	0	0	0	0	0	0	695	26
27	Other (specify):*	0	0	8,687	0	0	0	0	0	0	0	0	8,687	27
28	TOTAL General Administration	(871)	(130,143)	50,745	7,100	0	0	0	0	0	0	0	(73,169)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(5,549)	(124,224)	50,745	7,480	0	0	0	0	0	0	0	(71,548)	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	(3,956)	0	3,126	10,113	0	0	0	0	0	0	0	9,283	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,598)	0	6,215	13,230	0	0	0	0	0	0	0	17,847	32
33	Real Estate Taxes	0	0	460	0	0	0	0	0	0	0	0	460	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	458	55	0	0	0	0	0	0	0	513	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(5,554)	0	10,259	23,398	0	0	0	0	0	0	0	28,103	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):*	(91,600)	0	0	0	0	0	0	0	0	0	0	(91,600)	43
44	TOTAL Special Cost Centers	(91,600)	0	0	0	0	0	0	0	0	0	0	(91,600)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(102,703)	(124,224)	61,004	30,878	0	0	0	0	0	0	0	(135,045)	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%	\$ 3,253	\$ 3,253	1
2	V	2	Food		Petersen Health Care, Inc.	100.00%	110	110	2
3	V	3	Housekeeping		Petersen Health Care, Inc.	100.00%	25	25	3
4	V	4	Laundry		Petersen Health Care, Inc.	100.00%	5	5	4
5	V	5	Utilities		Petersen Health Care, Inc.	100.00%	257	257	5
6	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	1,805	1,805	6
7	V	7	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	433	433	7
8	V	10	Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	31	31	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	207,800	Petersen Health Care, Inc.	100.00%	60,083	(147,717)	11
12	V	19	Professional Services		Petersen Health Care, Inc.	100.00%	17,574	17,574	12
13	V								13
14	Total			\$ 207,800			\$ 83,576	\$ * (124,224)	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%	\$ 250	\$ 250	15
16	V	21	Clerical and General Office		Petersen Health Care, Inc.	100.00%	36,826	36,826	16
17	V	23	Inservice Training & Education		Petersen Health Care, Inc.	100.00%	61	61	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%	4,220	4,220	19
20	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	695	695	20
21	V	27	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	8,687	8,687	21
22	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	3,126	3,126	22
23	V	32	Interest		Petersen Health Care, Inc.	100.00%	6,215	6,215	23
24	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	460	460	24
25	V	34	Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0		25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	458	458	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			\$			\$ 61,004	\$ * 61,004	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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	1 Dietary	\$	Petersen Health Care II, Inc.	100.00%	\$ 0	\$	15
16	V	2 Food		Petersen Health Care II, Inc.	100.00%	0		16
17	V	3 Housekeeping		Petersen Health Care II, Inc.	100.00%	0		17
18	V	4 Laundry		Petersen Health Care II, Inc.	100.00%	0		18
19	V	5 Utilities		Petersen Health Care II, Inc.	100.00%	0		19
20	V	6 Maintenance		Petersen Health Care II, Inc.	100.00%	380	380	20
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	100.00%	0		21
22	V	10 Nursing and Medical Records		Petersen Health Care II, Inc.	100.00%	0		22
23	V	12 Social Services		Petersen Health Care II, Inc.	100.00%	0		23
24	V	17 Administrative		Petersen Health Care II, Inc.	100.00%	0		24
25	V	19 Professional Services		Petersen Health Care II, Inc.	100.00%	2,917	2,917	25
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Care II, Inc.	100.00%	16	16	26
27	V	21 Clerical and General Office		Petersen Health Care II, Inc.	100.00%	2,350	2,350	27
28	V	22 Employee Benefits & Payroll		Petersen Health Care II, Inc.	100.00%	1,512	1,512	28
29	V	23 Inservice Training & Education		Petersen Health Care II, Inc.	100.00%	33	33	29
30	V	24 Travel and Seminar		Petersen Health Care II, Inc.	100.00%	0		30
31	V	25 Other Admin. Staff Transport.		Petersen Health Care II, Inc.	100.00%	272	272	31
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care II, Inc.	100.00%	0		32
33	V	27 Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	100.00%	0		33
34	V	30 Depreciation		Petersen Health Care II, Inc.	100.00%	10,113	10,113	34
35	V	32 Interest		Petersen Health Care II, Inc.	100.00%	13,230	13,230	35
36	V	33 Real Estate Taxes		Petersen Health Care II, Inc.	100.00%	0		36
37	V	34 Rent-Facility and Grounds		Petersen Health Care II, Inc.	100.00%	0		37
38	V	35 Rent-Equipment & Vehicles		Petersen Health Care II, Inc.	100.00%	55	55	38
39	Total		\$			\$ 30,878	\$ * 30,878	39

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

Facility Name & ID Number Sullivan Rehab & Health Care Center # 0046425 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 I	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	11
12			Countryview Terrace	Louisville	Petersen Health Care I	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	13
14			Decatur Rehab & Health Care Center	Decatur	Petersen Health Care I	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

Sullivan Rehab & Health Care Center

0046425

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

Sullivan Rehab & Health Care Center

0046425

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 Sullivan Rehab & Health Care Center # 0046425 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 Sullivan Rehab & Health Care Center # 0046425 Report Period Beginning: 1/1/2012 Ending: 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	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	1,569,393	74	\$ 285,707	\$ 284,214	17,871	\$ 3,253	1
2	2	Food	Resident Days	1,569,393	74	9,632	0	17,871	110	2
3	3	Housekeeping	Resident Days	1,569,393	74	2,201	0	17,871	25	3
4	4	Laundry	Resident Days	1,569,393	74	397	0	17,871	5	4
5	5	Utilities	Resident Days	1,569,393	74	22,546	0	17,871	257	5
6	6	Maintenance	Resident Days	1,569,393	74	158,485	73,431	17,871	1,805	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,569,393	74	38,057	0	17,871	433	7
8	10	Nursing and Medical Records	Resident Days	1,569,393	74	2,750	0	17,871	31	8
9	10A	Therapy	Resident Days	1,569,393	74	0	0	17,871	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,569,393	74	0	0	17,871	0	10
11	17	Administrative	Resident Days	1,569,393	74	4,353,655	4,353,655	17,871	60,083	11
12	19	Professional Services	Resident Days	1,569,393	74	1,543,275	0	17,871	17,574	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,569,393	74	21,988	0	17,871	250	13
14	21	Clerical and General Office	Resident Days	1,569,393	74	3,233,970	2,816,787	17,871	36,826	14
15	23	Inservice Training & Education	Resident Days	1,569,393	74	5,397	0	17,871	61	15
16	24	Travel and Seminar	Resident Days	1,569,393	74	535	0	17,871	6	16
17	25	Other Admin. Staff Transport.	Resident Days	1,569,393	74	370,568	0	17,871	4,220	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,569,393	74	61,077	0	17,871	695	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,569,393	74	762,912	0	17,871	8,687	19
20	30	Depreciation	Resident Days	1,569,393	74	274,514	0	17,871	3,126	20
21	32	Interest	Resident Days	1,569,393	74	545,764	0	17,871	6,215	21
22	33	Real Estate Taxes	Resident Days	1,569,393	74	40,424	0	17,871	460	22
23	34	Rent-Facility and Grounds	Resident Days	1,569,393	74	0	0	17,871	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,569,393	74	40,223	0	17,871	458	24
25	TOTALS					\$ 11,774,077	\$ 7,528,087		\$ 144,580	25

Facility Name & ID Number Sullivan Rehab & Health Care Center# 0046425

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 II, 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	336,407	13	\$	\$	17,871	\$	1
2	2	Food	Resident Days	336,407	13			17,871		2
3	3	Housekeeping	Resident Days	336,407	13			17,871		3
4	4	Laundry	Resident Days	336,407	13			17,871		4
5	5	Utilities	Resident Days	336,407	13			17,871		5
6	6	Maintenance	Resident Days	336,407	13	7,156		17,871	380	6
7	7	Mgmt. Allocation of Benefits	Resident Days	336,407	13			17,871		7
8	10	Nursing and Medical Records	Resident Days	336,407	13			17,871		8
9	15	Mgmt. Allocation of Benefits	Resident Days	336,407	13			17,871		9
10	17	Administrative	Resident Days	336,407	13			17,871		10
11	19	Professional Services	Resident Days	336,407	13	54,918		17,871	2,917	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	336,407	13	300		17,871	16	12
13	21	Clerical and General Office	Resident Days	336,407	13	44,246		17,871	2,350	13
14	22	Employee Benefits & Payroll	Resident Days	336,407	13	28,459		17,871	1,512	14
15	23	Inservice Training & Education	Resident Days	336,407	13	617		17,871	33	15
16	24	Travel and Seminar	Resident Days	336,407	13			17,871		16
17	25	Other Admin. Staff Transport.	Resident Days	336,407	13	5,121		17,871	272	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	336,407	13			17,871		18
19	27	Mgmt. Allocation of Benefits	Resident Days	336,407	13			17,871		19
20	30	Depreciation	Resident Days	336,407	13	190,366		17,871	10,113	20
21	32	Interest	Resident Days	336,407	13	249,037		17,871	13,230	21
22	33	Real Estate Taxes	Resident Days	336,407	13			17,871		22
23	34	Rent-Facility and Grounds	Resident Days	336,407	13			17,871		23
24	35	Rent-Equipment & Vehicles	Resident Days	336,407	13	1,038		17,871	55	24
25	TOTALS					\$ 581,258	\$		\$ 30,878	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	First Merit		X	Mortgage	Varies	2/1/12	\$ 1,743,600	\$ 1,704,425	1/31/17	Varies	\$ 74,769	1	
2												2	
3												3	
4								Home Office Allocation-PHC			6,215	4	
5								Home Office Allocation-PHC II			13,230	5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 1,743,600	\$ 1,704,425			\$ 94,214	9	
	B. Non-Facility Related*												
10												10	
11								Interest Income Offset			(1,333)	11	
12								MCR Penalty Withholding Interest			265	12	
13								Offset of MCR Penalty			(265)	13	
14	TOTAL Non-Facility Related						\$	\$			\$ (1,333)	14	
15	TOTALS (line 9+line14)						\$ 1,743,600	\$ 1,704,425			\$ 92,881	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.			\$	42,213	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	\$	44,333	2
3. Under or (over) accrual (line 2 minus line 1).			\$	2,120	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	45,660	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.				460	
TOTAL REFUND \$ For 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.			\$	48,240	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2007	41,554	8	
		2008	41,471	9	
		2009	42,056	10	
		2010	42,469	11	
		2011	44,333	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 Sullivan Rehab & Health Care Center COUNTY Moultrie

FACILITY IDPH LICENSE NUMBER 0046425

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.	08-08-11-400-004	Long-Term Care Facility	\$ 43,980.80	\$ 43,980.80
2.	08-08-12-300-073	Long-Term Care Facility	\$ 351.94	\$ 351.94
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
TOTALS			\$ 44,332.74	\$ 44,332.74

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: 28,000

B. General Construction Type: Exterior Brick & Block

Frame Concrete

Number of Stories 1

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

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

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	339,095	2003	\$ 100,001	1
2					2
3	TOTALS	339,095		\$ 100,001	3

Facility Name & ID Number Sullivan Rehab & Health Care Center

0046425

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

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	123		2003	1975	\$ 1,560,545	\$	39	\$ 40,014	\$ 40,014	\$ 373,464
5										
6										
7										
8										
	Improvement Type**									
9	Carpeting		2004		4,808		25	192	192	1,584
10	Fire Alarms		2004		1,524		25	61	61	478
11	Doors		2004		3,067		5			3,067
12	Smoke Alarms		2004		1,227		7	13	13	1,227
13	Land Improvements		2006		7,262		15	484	484	3,146
14	New Roof		2006		28,308		25	1,132	1,132	7,358
15	Kitchen Remodel		2006		22,241		25	890	890	5,785
16	Landscaping		2006		2,434		15	162	162	1,053
17	Sidewalks		2007		1,785		15	120	120	660
18	Sprinkler System		2008		14,839		25	594	594	2,673
19	Back Flow		2009		5,470		7	782	782	2,737
20	Water Heater		2009		2,983		5	596	596	2,086
21	Roof Repairs		2011		2,536		7	362	362	543
22										
23										
24										
25										
26										
27										
28										
29										
30	Land Improvements Booked					765			(765)	
31	Building Booked					40,014			(40,014)	
32	Building Improvement Booked					4,172			(4,172)	
33										
34	2012-Home Office Allocation-Building Improvements				8,358			200	200	
35	2012-Home Office Allocation-Land Improvements				780			50	50	
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)		\$ 1,668,167	\$ 44,951		\$ 45,652	\$ 701	\$ 405,861	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$38,366	\$8,243	\$3,836	\$ (4,407)	5-10 yrs.	\$17,812	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	615,105					615,105	73
74	Home Office Allocation			12,989	12,989			74
75	TOTALS	\$653,471	\$8,243	\$16,825	\$8,582		\$632,917	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	2003 Ford	2003	\$31,116	\$		\$		\$31,116	76
77										77
78										78
79										79
80	TOTALS			\$31,116	\$	\$	\$		\$31,116	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$2,452,755	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$53,194	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$62,477	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$9,283	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$1,069,894	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: 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: \$ 22,729
- Description: See Attached Schedule 14A
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2012 Ford E250 Van	\$ 822.05	\$ 4,447	17
18					18
19					19
20					20
21	TOTAL		\$ 822.05	\$ 4,447	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.
13.
14.
- /2013
- /2014
- /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.

Sullivan Health Care Center
0046425
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	\$ 18,261
Dishwasher	-
Laundry Equipment	-
Copier	3,955
Home Office Allocation	513
	<u>22,729</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	\$	2,430	\$ 36,445	\$	2,430	\$ 36,445	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		920	13,804		920	13,804	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(1, 2,3)	1784 hrs	24,257	6,888	103,323	216	8,672	127,796	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				116,425		116,425	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			\$ 24,257	10,238	\$ 153,572	\$ 116,641	12,022	\$ 294,470	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	\$ 1,822,121	\$ 1,822,121	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 126,000)	599,592	599,592	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	38,867	38,867	6
7	Other Prepaid Expenses	13,122	13,122	7
8	Accounts Receivable (Prepaid Leases)	5,824	5,824	8
9	Other(specify): Employee Education Loans	4,328	4,328	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,483,854	\$ 2,483,854	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	111,481	100,001	13
14	Buildings, at Historical Cost	1,560,545	1,568,903	14
15	Leasehold Improvements, at Historical Cost	82,708	99,264	15
16	Equipment, at Historical Cost	688,882	684,587	16
17	Accumulated Depreciation (book methods)	(1,072,936)	(1,069,894)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,370,680	\$ 1,382,861	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,854,534	\$ 3,866,715	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 466,395	\$ 466,395	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	86,991	86,991	30
31	Accrued Taxes Payable (excluding real estate taxes)	13,937	13,937	31
32	Accrued Real Estate Taxes(Sch.IX-B)	45,660	45,660	32
33	Accrued Interest Payable	5,985	5,985	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	46,668	46,668	36
37	Accrued Management Fees	85,991	85,991	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 751,627	\$ 751,627	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,704,425	1,704,425	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	A/P-Other	22,417	22,417	43
44	Due to Related Parties	1,077	1,077	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,727,919	\$ 1,727,919	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,479,546	\$ 2,479,546	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,374,988	\$ 1,387,169	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,854,534	\$ 3,866,715	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,591,768	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)	\$ 1,591,767	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(216,779)	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)	\$ (216,779)	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)	\$ 1,374,988	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Sullivan Rehab & Health Care Center# 0046425Report 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	\$ 2,523,400	1
2	Discounts and Allowances for all Levels	(354,344)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,169,056	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	357,320	6
7	Oxygen	4,529	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 361,849	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	4,338	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	184,124	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	10,262	20
21	Other Medical Services	7,223	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 205,947	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,333	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,333	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	562	28
28a	Transportation Revenue	340	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 902	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,739,087	30

	1		2
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	595,717	31
32	Health Care	1,185,077	32
33	General Administration	534,531	33
	B. Capital Expense		
34	Ownership	202,671	34
	C. Ancillary Expense		
35	Special Cost Centers	208,025	35
36	Provider Participation Fee	229,845	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,955,866	40
41	Income before Income Taxes (line 30 minus line 40)**	(216,779)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (216,779)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,355,725	44
45	Private Pay - Net Inpatient Revenue	469,775	45
46	Medicare - Net Inpatient Revenue	368,588	46
47	Other-(specify) <u>Veteran's Contractual Allowance</u>	(2,083)	47
48	Other-(specify) <u>Charity and Insurance Contractual Allowance</u>	(22,949)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,169,056	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	1,695	1,695	\$ 46,007	\$ 27.14	1
2	Assistant Director of Nursing	2,289	2,393	52,036	21.75	2
3	Registered Nurses	1,015	1,079	25,287	23.44	3
4	Licensed Practical Nurses	14,016	14,388	287,313	19.97	4
5	CNAs & Orderlies	31,402	32,615	365,432	11.20	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,673	1,784	24,257	13.60	8
9	Activity Director	1,862	1,966	22,319	11.35	9
10	Activity Assistants					10
11	Social Service Workers	1,889	2,049	34,044	16.61	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	37,036	17.81	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,937	12,638	109,594	8.67	15
16	Dishwashers					16
17	Maintenance Workers	1,972	2,076	31,252	15.05	17
18	Housekeepers	11,885	12,315	114,885	9.33	18
19	Laundry					19
20	Administrator	2,080	2,080	60,083	28.89	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,080	2,080	26,655	12.81	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Care Plan Coord</u>	1,122	1,138	27,075	23.79	33
34	TOTAL (lines 1 - 33)	88,997	92,376	\$ 1,263,275 *	\$ 13.68	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	12,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,508	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	8	195	L10A, C3	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	8	\$ 15,703		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	622	\$ 19,736	L10, C3	50
51	Licensed Practical Nurses	1,236	35,680	L10, C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,858	\$ 55,416		53

STATE OF ILLINOIS

Facility Name & ID Number

Sullivan Rehab & Health Care Center

0046425

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	
Charles Pullen		Administrator	0	\$ 60,083	Workers' Compensation Insurance		\$ 48,039	IDPH License Fee		\$ 3,980	
					Unemployment Compensation Insurance		25,274	Advertising: Employee Recruitment		223	
					FICA Taxes		94,715	Health Care Worker Background Check			
					Employee Health Insurance		10,493	(Indicate # of checks performed)			
					Employee Meals			Patient Background Checks		127 1,270	
					Illinois Municipal Retirement Fund (IMRF)*			Miscellaneous Licenses & Permits		125	
					Employee Relations		1,714	Miscellaneous Dues & Subscriptions		309	
					Employee Retirement		1,696	Home Office Allocation		266	
					Home Office Allocation		1,512				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$ 60,083				Less: Public Relations Expense		(309)	
B. Administrative - Other								Non-allowable advertising		()	
Description			Amount					Yellow page advertising		()	
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 207,800					TOTAL (agree to Sch. V, line 20, col. 8)		\$ 5,864	
				TOTAL (agree to Schedule V, line 22, col.8)		\$ 183,443					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 207,800	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**				
C. Professional Services				Description		Line #	Amount	Description		Amount	
Vendor/Payee		Type	Amount					Out-of-State Travel		\$	
E-Health Data Solutions		Computer Services	\$ 1,547								
Mediacom		Computer Services	1,366								
Honkamp, Krueger and Co.		Accounting Services	58	N/A							
Allscripts		Accounting Services	1,200					In-State Travel			
Heyl, Royster, Voelker & Allen		Reversal of 2011 Invoice	(4,585)								
Healthlink		Reversal of 2009 Invoice	(371)								
Moultrie Co. Circuit Clerk		Filing Fees	120								
Brown, Hay & Stephens		Legal Fees	48,443					Seminar Expense			
Mary J Dyck		Legal Fees	7,908								
Esquire Solutions		Legal Fees	(375)					Home Office Allocation		6	
								Entertainment Expense		()	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 55,311	TOTAL			\$	(agree to Sch. V, line 24, col. 8)		\$ 6	

* Attach copy of IMRF notifications

**See instructions.

Sullivan Health Care Center
0046425
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)		55,311
Home Office Allocation		
Sorling Northrup	Legal	56
Ginoli & Company	Accountants	1,249
Miscellaneous	Computer Services	48
Nebo Systems	Computer Services	2
Advanced Answers on Demand	Computer Services	2,715
Access 2 Go	Computer Services	114
Stratus Networks	Computer Services	112
Kemper Technology	Computer Services	185
CCH	Computer Services	10
Medifax	Computer Services	22
Vision Share/Ability Network	Computer Services	207
Barracuda	Computer Services	7
CIAN	Computer Services	56
Comcast	Computer Services	17
Postini	Computer Services	176
Optimizer Systems	Other Prof Fees	28
Marotta Gund Budd & Dzera	Other Prof Fees	12,574
David Budde	Other Prof Fees	10
Courtney Bourban	Other Prof Fees	155
All Scripts	Other Prof Fees	675
Heritage Enterprises	Other Prof Fees	11
Miscellaneous Vendors	Other Prof Fees	28
Katten Muchin Rosenman	Legal	688
U.S. Bank	Accountants	877
Medifax-EDI	Computer Services	68

Polaris Group	Other Prof Fees	272
Healthlink	Other Prof Fees	129
Total (agree to Schedule V, line 19, column 8)		<u>75,802</u>

Sullivan Health Care Center
0046425

Period Beginning 1/1/2012
Period End 12/31/2012

Schedule 21B

XIX. SUPPORT SCHEDULE
Legal Fees

Facility			
	Invoice	Allocation	
Vendor/Payee	Total	%	Total
Brown, Hay and Stephens	1,920.00	100%	1,920
Heyl Royster-Reversal of 2011 Inv	(5,087.50)	100%	(5,087)
Brown, Hay and Stephens	4,757.43	100%	4,757
Heyl Royster	502.57	100%	502
Heyl Royster	2.42	100%	2
Moultrie County Circuit Clerk	120.00	100%	120
Brown, Hay and Stephens	3,321.17	100%	3,321
Brown, Hay and Stephens	1,449.48	100%	1,449
Brown, Hay and Stephens	4,113.81	100%	4,114
Brown, Hay and Stephens	2,130.00	100%	2,130
Brown, Hay and Stephens	22,858.98	100%	22,859
Brown, Hay and Stephens	6,110.39	100%	6,110
Mary J. Dyck	7,908.00	100%	7,908
Brown, Hay and Stephens	1,110.00	100%	1,110
Brown, Hay and Stephens	672.18	100%	672
Heyl Royster-Reversal of 2011 Inv	(2.42)	100%	(2)
Esquire Solutions	(375.27)	100%	(375)
Home Office Allocation			
Sorling Northrup	5,053.00	1.10%	56
Katten Muchin Rosenman	12,947.00	5.31%	688
Total Legal Fees			52,255

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. \$ 6,737 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. \$ 229,845
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. \$ 4,338
- (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. \$ 340
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

10:02 AM

6/14/2013

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	-135,045	equal to	-135,045	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	92,881	equal to	92,881	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	48,240	equal to	48,240	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	62,477	equal to	62,477	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	27,176	equal to	27,176	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	24,257	equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	202,497	equal to	202,497	0	O.K.	Pg16 Z12+Z14..	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv.- Supplies	116,641	equal to	116,641	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	595,717	equal to	595,717	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	1,185,077	equal to	1,185,077	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	534,531	equal to	534,531	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	202,671	equal to	202,671	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	208,025	equal to	208,025	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24++	N/A	38to41+43	4
Income Stat. Prov. Partic.	229,845	equal to	229,845	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	803,150	equal to	803,150	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	22,319	equal to	22,319	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	34,044	equal to	34,044	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	146,630	equal to	146,630	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	31,252	equal to	31,252	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	114,885	equal to	114,885	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	0	equal to		0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	60,083	equal to		0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	26,655	equal to	26,655	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	1,263,275	equal to	1,203,192	60,083	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	12,000	< or = to	12,000	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	58,924	< or = to	55,111	3,813	FAILED	Pg20 X14..X16+	B. & C.	7to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to	7,423	-7,423	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.	60,083	equal to		0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	207,800	equal to	207,800	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3

Supp. Sched.- Prof. Serv.	55,311	equal to	55,311	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	183,443	equal to	183,443	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	5,864	equal to	5,864	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	229,845	equal to	229,845	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	0	< or = to	1,512	-1,512	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	2,104	equal to	2,308	-204	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	-32,342	equal to	-32,342	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4I	B.	14	8
Total loan balance	1,704,425	equal to	1,704,425	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	45,660	equal to	45,660	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	100,001	equal to	100,001	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	1,668,167	equal to	1,668,167	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	684,587	equal to	684,587	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	1,069,894	equal to	1,069,894	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	1,374,988	equal to	1,374,988	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	-216,779	equal to	-216,779	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..5	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	3,854,534	equal to	3,854,534	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	146,630	11,938	0	158,568	0	158,568	3,253	161,821
2. Food Purchase	0	109,449	0	109,449	0	109,449	-4,228	105,221
3. Housekeeping	114,885	20,253	0	135,138	0	135,138	25	135,163
4. Laundry	0	4,140	0	4,140	0	4,140	5	4,145
5. Heat and Other Utilities	0	0	134,616	134,616	0	134,616	257	134,873
6. Maintenance	31,252	7,726	14,828	53,806	0	53,806	2,185	55,991
7. Other (specify)*	0	0	0	0	0	0	433	433
8. Total General Services	292,767	153,506	149,444	595,717	0	595,717	1,930	597,647
9. Medical Director	0	0	12,000	12,000	0	12,000	0	12,000
10. Nursing & Medical Records	803,150	72,195	55,111	930,456	0	930,456	31	930,487
10a. Therapy	24,257	216	153,572	178,045	0	178,045	0	178,045
11. Activities	22,319	764	7,423	30,506	0	30,506	-340	30,166
12. Social Services	34,044	26	0	34,070	0	34,070	0	34,070
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	883,770	73,201	228,106	1,185,077	0	1,185,077	-309	1,184,768
17. Administrative	0	0	207,800	207,800	0	207,800	-147,717	60,083
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	55,311	55,311	0	55,311	20,491	75,802
20. Fees, Subscriptions & Promotion	0	0	5,907	5,907	0	5,907	-43	5,864
21. Clerical & General Office	26,655	4,831	8,337	39,823	0	39,823	38,614	78,437
22. Employee Benefits & Payroll	0	0	181,931	181,931	0	181,931	1,512	183,443
23. Inservice Training & Education	0	0	0	0	0	0	94	94
24. Travel and Seminar	0	0	0	0	0	0	6	6
25. Other Admin. Staff Trans	0	0	5,001	5,001	0	5,001	4,492	9,493
26. Insurance-Prop.Liab.Malpractice	0	0	38,758	38,758	0	38,758	695	39,453
27. Other (specify)*	0	0	0	0	0	0	8,687	8,687
28. Total General Adminis	26,655	4,831	503,045	534,531	0	534,531	-73,169	461,362
29. Total General Administrative	1,203,192	231,538	880,595	2,315,325	0	2,315,325	-71,548	2,243,777
30. Depreciation	0	0	53,194	53,194	0	53,194	9,283	62,477
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	75,034	75,034	0	75,034	17,847	92,881
33. Real Estate	0	0	47,780	47,780	0	47,780	460	48,240

34. Rent - Facility & Grounds	0	0	0	0	0	0	0	0
35. Rent - Equipment & Vehicles	0	0	26,663	26,663	0	26,663	513	27,176
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	202,671	202,671	0	202,671	28,103	230,774
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	116,425	0	116,425	0	116,425	0	116,425
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	229,845	229,845	0	229,845	0	229,845
43. Other (specify):*	0	3,064	88,536	91,600	0	91,600	-91,600	0
44. Total Special Cost Ce	0	119,489	318,381	437,870	0	437,870	-91,600	346,270
45. Grand Total	1,203,192	351,027	1,401,647	2,955,866	0	2,955,866	-135,045	2,820,821

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	1,822,121	1,822,121
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	599,592	599,592
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	38,867	38,867
7. Other Prepaid Expenses	13,122	13,122
8. Accounts Receivable-Owner/Related Party	-1,077	-1,077
9. Other (specify):	10,152	10,152
10. Total current assets	2,482,777	2,482,777
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	111,481	100,001
14. Buildings, at Historical Cost	1,560,545	1,568,903
15. Leasehold Improvements, Historical Cost	82,708	99,264
16. Equipment, at Historical Cost	688,882	684,587
17. Accumulated Depreciation (book methods)	-1,072,936	-1,069,894
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	1,370,680	1,382,861
25. Total Assets	3,853,457	3,865,638
CURRENT LIABILITIES		
26. Accounts Payable	466,395	466,395
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	86,991	86,991
31. Accrued Taxes Payable	13,937	13,937
32. Accrued Real Estate Taxes	45,660	45,660
33. Accrued Interest Payable	5,985	5,985
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	46,668	46,668

37. Other Current Liabilities (specify):	85,991	85,991
38. Total Current Liabilities	751,627	751,627
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	1,704,425	1,704,425
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	22,417	22,417
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	1,726,842	1,726,842
46.Total Liabilities	2,478,469	2,478,469
47.Total Equity	1,374,988	1,387,169
48.Total Liabilities and Equity	3,853,457	3,865,638

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	2,523,400
2. Discounts and Allowances for all Levels	-354,344
Subtotal - Inpatient Care	2,169,056
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	357,320
7. Oxygen	4,529
Subtotal - Anciliary Revenue	361,849
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	4,338
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	184,124
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiology and X-Ray	10,262
21. Other Medical Services	7,223
22. Laundry	0
Subtotal - Other Operating Revenue	205,947
24. Contributions	0
25. Interest and Other Investments Income	1,333
Subtotal - Non-Operating Revenue	1,333
27. Other Revenue (specify):	0
28. Other Revenue (specify):	902
Subtotal - Other Revenue	902
30. Total Revenue	2,739,087
31. General Services	595,717
32. Health Care	1,185,077
33. General Administration	534,531
34. Ownership	202,671

35. Special Cost Centers	208,025
35. Provider Participation Fee	229,845
37. Other	0
40. Total Expenses	2,955,866
41. Income Before Income Taxes	-216,779
42. Income Taxes	0
43. Net Income or Loss for the Year	-216,779

Enter Cost Center Expenses

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

6/14/201310:02:41 AM

HSA Number:

4

Name:

Sullivan Rehab & 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:

44,895

Occupancy:

17,872

Pct. of occupancy:

39.81%

Illinois Public Aid Support Rate:

\$

Genl Services Salary/Wage:

292,767

Col 1, Line 8 ---Audit Adj:

Genl Admin Salary/Wage:

26,655

Col 1, Line 28 ---Audit Adj:

Total Salary Wage:

1,203,192

Col 1, Line 44 ---Audit Adj:

Employee Benefits:

183,443

Col 8, Line 22 ---Audit Adj:

Total General Services:

597,647

Col 8, Line 8 ---Audit Adj:

Total General Admin:

461,362

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

\$292,767
\$1,203,192
24.3325%
\$183,443

\$44,636
\$597,647
\$642,283

\$26,655
\$1,203,192
2.2154%

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

\$183,443
\$4,064
\$461,362
\$183,443
\$281,983

6.5
0.526315789
1344
1351.026316
907.00
444

1
1

\$642,283
1

\$642,283

\$281,983
<u>1</u>
\$281,983
<u>\$924,266</u>

\$35.78

\$924,266
<u>17,872</u>
<u>\$51.72</u>

44,895
<u>0.93</u>
41,752
<u>17,872</u>
23,880
7,960
<u>17,872</u>
<u>25,832</u>

\$924,266

25832

\$35.78

\$47.44

\$35.78

\$11.66

0.5

\$5.83

\$35.78

41.61

\$47.44

\$35.78

\$11.66

0.5
<u>\$5.83</u>
<u>3.795</u>
\$3.795
<u>\$35.78</u>
\$39.58
<u>\$39.58</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