

		FOR BHF USE					

LL1

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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: 0050203

Facility Name: Pleasant View Rehab & Health Care

Address: 500 N. Jackson Street Morrison 61270
Number City Zip Code

County: Whiteside

Telephone Number: (815) 772-7288 Fax # (815)772-2399

HFS ID Number:

Date of Initial License for Current Owners: 4/1/09

Type of Ownership:

☐	VOLUNTARY,NON-PROFIT	☒	PROPRIETARY	☐	GOVERNMENTAL
☐	Charitable Corp.	☐	Individual	☐	State
☐	Trust	☐	Partnership	☐	County
IRS Exemption Code		☐	Corporation	☐	Other
		☐	"Sub-S" Corp.		
		☒	Limited Liability Co.		
		☐	Trust		
		☐	Other		

In the event there are further questions about this report, please contact:
Name: Larry Templin Telephone Number: (309) 689-5869
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 1/1/2011 to 12/31/2011
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)		(Date)
	(Type or Print Name)	Mark B. Petersen	
Paid Preparer	(Title)	Chief Executive Officer	
	(Signed)		(Date)
	(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 Pleasant View Rehab & Health Care

0050203 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds					
N/A					
1	2	3	4		
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	8	Skilled (SNF)	8	2,920	1
2		Skilled Pediatric (SNF/PED)			2
3	66	Intermediate (ICF)	66	24,090	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	74	TOTALS	74	27,010	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			1,269	1,269	8
9	SNF/PED					9
10	ICF	13,068	4,507	116	17,691	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,068	4,507	1,385	18,960	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.20%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☒ NO ☐ Non-allowable costs have been eliminated in Schedule V, Column 7

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

I. On what date did you start providing long term care at this location?
Date started 4/1/2009

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 4/1/2009 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 8 and days of care provided 1,269

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/11 Fiscal Year: 12/31/11
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Pleasant View Rehab & Health Care # 0050203 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	A. General Services	1	2	3	4	5	6	7	8			
1	Dietary	139,917	11,923		151,840		151,840	3,825	155,665			1
2	Food Purchase		111,533		111,533		111,533	(5,643)	105,890			2
3	Housekeeping	64,248	22,783		87,031		87,031	25	87,056			3
4	Laundry	28,109	14,604		42,713		42,713		42,713			4
5	Heat and Other Utilities			65,613	65,613		65,613	250	65,863			5
6	Maintenance	44,438	8,723	20,126	73,287		73,287	1,459	74,746			6
7	Other (specify):* <u>Home Off. Ben. All.</u>							872	872			7
8	TOTAL General Services	276,712	169,566	85,739	532,017		532,017	788	532,805			8
	B. Health Care and Programs											
9	Medical Director			24,200	24,200		24,200		24,200			9
10	Nursing and Medical Records	923,369	67,877	8,025	999,271		999,271	38	999,309			10
10a	Therapy			139,154	139,154		139,154		139,154			10a
11	Activities	37,896	396	25	38,317		38,317	(5,532)	32,785			11
12	Social Services	28,081		4,060	32,141		32,141		32,141			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* <u>Home Off. Ben. All.</u>											15
16	TOTAL Health Care and Programs	989,346	68,273	175,464	1,233,083		1,233,083	(5,494)	1,227,589			16
	C. General Administration											
17	Administrative			195,300	195,300		195,300	(138,325)	56,975			17
18	Directors Fees											18
19	Professional Services			5,073	5,073		5,073	6,868	11,941			19
20	Dues, Fees, Subscriptions & Promotions			11,406	11,406		11,406	(142)	11,264			20
21	Clerical & General Office Expenses	25,340	4,265	10,814	40,419		40,419	38,538	78,957			21
22	Employee Benefits & Payroll Taxes			171,494	171,494		171,494		171,494			22
23	Inservice Training & Education							128	128			23
24	Travel and Seminar							38	38			24
25	Other Admin. Staff Transportation			9,272	9,272		9,272	3,277	12,549			25
26	Insurance-Prop.Liab.Malpractice			24,472	24,472		24,472	887	25,359			26
27	Other (specify):* <u>Home Off. Ben. All.</u>							14,493	14,493			27
28	TOTAL General Administration	25,340	4,265	427,831	457,436		457,436	(74,238)	383,198			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,291,398	242,104	689,034	2,222,536		2,222,536	(78,944)	2,143,592			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			2,994	2,994		2,994	90,723	93,717			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			10,629	10,629		10,629	128,605	139,234			32
33	Real Estate Taxes							39,808	39,808			33
34	Rent-Facility & Grounds			183,239	183,239		183,239	(183,239)				34
35	Rent-Equipment & Vehicles			2,897	2,897		2,897	559	3,456			35
36	Other (specify):*											36
37	TOTAL Ownership			199,759	199,759		199,759	76,456	276,215			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		66,105		66,105		66,105		66,105			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			40,515	40,515		40,515		40,515			42
43	Other (specify):* Non-allowable Costs	29,400	1,320	27,707	58,427		58,427	(58,427)				43
44	TOTAL Special Cost Centers	29,400	67,425	68,222	165,047		165,047	(58,427)	106,620			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,320,798	309,529	957,015	2,587,342		2,587,342	(60,915)	2,526,427			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(5,661)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,652)	43		5
6	Rented Facility Space	(101)	6		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	5,884	30		9
10	Interest and Other Investment Income	(32)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(327)	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	(3,228)	43		18
19	Entertainment				19
20	Contributions	(1,535)	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	(3,324)	43		24
25	Fund Raising, Advertising and Promotional	(7,850)	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	(47,595)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (68,421)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	7,506	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 7,506		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (60,915)		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (4,304)	43	1
2	X-Rays-Part A	(1,911)	43	2
3	Offset Chamber of Commerce Dues	(450)	20	3
4	Disallowed Pet Expense	(781)	43	4
5	Offset Miscellaneous Office Supplies Revenue	(707)	21	5
6	Offset Transportation Revenue	(5,532)	11	6
7	Resident Flowers	(329)	43	7
8	Disallowed Special Events	(786)	43	8
9	Disallowed Marketing Salaries	(29,400)	43	9
10	Disallowed IDES Interest	(3,395)	32	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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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	(47,595)		49

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	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V	1	Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 3,825	\$ 3,825	1
2	V	2	Food		Petersen Health Care, Inc.	100.00%	18	18	2
3	V	3	Housekeeping		Petersen Health Care, Inc.	100.00%	25	25	3
4	V	4	Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5	Utilities		Petersen Health Care, Inc.	100.00%	250	250	5
6	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	1,560	1,560	6
7	V	7	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	872	872	7
8	V	10	Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	38	38	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	195,300	Petersen Health Care, Inc.	100.00%	56,975	(138,325)	11
12	V	19	Professional Services		Petersen Health Care, Inc.	100.00%	4,376	4,376	12
13	V								13
14	Total			\$ 195,300			\$ 67,939	\$ * (127,361)	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%	\$ 308	\$ 308	15
16	V	21	Clerical and General Office		Petersen Health Care, Inc.	100.00%	35,657	35,657	16
17	V	23	Inservice Training & Education		Petersen Health Care, Inc.	100.00%	128	128	17
18	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	38	38	18
19	V	25	Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	3,277	3,277	19
20	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	887	887	20
21	V	27	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	14,493	14,493	21
22	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	5,123	5,123	22
23	V	32	Interest		Petersen Health Care, Inc.	100.00%	6,167	6,167	23
24	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	315	315	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%	559	559	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			\$			\$ 66,952	\$ * 66,952	39

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

VII. RELATED PARTIES (continued)

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

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	\$	Petersen Health Operations III, LLC	100.00%	\$ 0	\$	15
16	V	2	Food		Petersen Health Operations III, LLC	100.00%	0		16
17	V	3	Housekeeping		Petersen Health Operations III, LLC	100.00%	0		17
18	V	4	Laundry		Petersen Health Operations III, LLC	100.00%	0		18
19	V	5	Utilities		Petersen Health Operations III, LLC	100.00%	0		19
20	V	6	Maintenance		Petersen Health Operations III, LLC	100.00%	0		20
21	V	7	Mgmt. Allocation of Benefits		Petersen Health Operations III, LLC	100.00%	0		21
22	V	10	Nursing and Medical Records		Petersen Health Operations III, LLC	100.00%	0		22
23	V	10A	Therapy		Petersen Health Operations III, LLC	100.00%	0		23
24	V	15	Mgmt. Allocation of Benefits		Petersen Health Operations III, LLC	100.00%	0		24
25	V	17	Administrative		Petersen Health Operations III, LLC	100.00%	0		25
26	V	19	Professional Services		Petersen Health Operations III, LLC	100.00%	2,492	2,492	26
27	V	20	Dues, Fees, Subs & Promotions		Petersen Health Operations III, LLC	100.00%	0		27
28	V	21	Clerical and General Office		Petersen Health Operations III, LLC	100.00%	3,588	3,588	28
29	V	23	Inservice Training & Education		Petersen Health Operations III, LLC	100.00%	0		29
30	V	24	Travel and Seminar		Petersen Health Operations III, LLC	100.00%	0		30
31	V	25	Other Admin. Staff Transport.		Petersen Health Operations III, LLC	100.00%	0		31
32	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Operations III, LLC	100.00%	0		32
33	V	27	Mgmt. Allocation of Benefits		Petersen Health Operations III, LLC	100.00%	0		33
34	V	30	Depreciation		Petersen Health Operations III, LLC	100.00%	0		34
35	V	32	Interest		Petersen Health Operations III, LLC	100.00%	0		35
36	V	33	Real Estate Taxes		Petersen Health Operations III, LLC	100.00%	0		36
37	V	34	Rent-Facility and Grounds		Petersen Health Operations III, LLC	100.00%	0		37
38	V	35	Rent-Equipment & Vehicles		Petersen Health Operations III, LLC	100.00%	0		38
39	Total			\$			\$ 6,080	\$ *	6,080 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.

☒ X

 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	30	Depreciation	\$	Petersen Companies III, LLC	100.00%	\$ 79,716	\$ 79,716	15
16	V	32	Amortization		Petersen Companies III, LLC	100.00%	13,569	13,569	16
17	V	32	Interest		Petersen Companies III, LLC	100.00%	112,296	112,296	17
18	V	33	Real Estate Taxes		Petersen Companies III, LLC	100.00%	39,493	39,493	18
19	V	34	Rent-Facility Grounds	183,239	Petersen Companies III, LLC	100.00%		(183,239)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								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			\$ 183,239			\$ 245,074	\$ * 61,835	39

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

Facility Name & ID Number

Pleasant View Rehab & Health Care

0050203

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

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				1
2			Arcola Health Care Center	Arcola				2
3			Aspen Rehab & Health Care	Silvis				3
4			Batavia Rehab & Health Care Center	Batavia				4
5			Bement Health Care Center	Bement				5
6			Benton Rehab & Health Care Center	Benton				6
7			Bloomington Rehab & Health Care Center	Bloomington				7
8			Casey Health Care Center	Casey				8
9			Charleston Rehab & Health Care Center	Charleston				9
10			Cisne Rehab & Health Care Center	Cisne				10
11			Countryview Care Center of Macomb	Macomb				11
12			Countryview Terrace	Louisville				12
13			Cumberland Rehab & Health Care Center	Greenup				13
14			Decatur Rehab & Health Care Center	Decatur				14
15			Eastside Health & Rehabilitation Center	Pittsfield				15
16			Eastview Terrace	Sullivan				16
17			El Paso Health Care Center	El Paso				17
18			Enfield Rehab & Health Care Center	Enfield				18
19			Farmer City Rehab & Health Care Center	Farmer City				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 Pleasant View Rehab & Health Care

0050203

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

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 Pleasant View Rehab & Health Care

0050203

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

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								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

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			Ozark Rehab & Health Care Center	Osage Beach, MO	Petersen Companies, LLC	Peoria	Mgmt/Bookkeeping	1
2			South Shore Health Care, LLC	Gary, IN	Petersen Health Care II, Inc.	Peoria	Mgmt/Bookkeeping	2
3			Cedargate Skilled Nursing Facility	Poplar Bluff, MO	Petersen Health Care, Inc.	Peoria	Mgmt/Bookkeeping	3
4			Tarkio Rehab & Health Care Center	Tarkio, MO	Petersen Health Enterprises, LLC	Peoria	Mgmt/Bookkeeping	4
5			Shangri-la Rehab & Living Center	Blue Springs, MO	Petersen Health Operations LLC	Peoria	Mgmt/Bookkeeping	5
6			Prairie Rose Care Center	Pana	Petersen Health Systems, Inc.	Peoria	Mgmt/Bookkeeping	6
7			Illini Heritage Rehab & Health Center	Champaign	Petersen Hotels LLC	Peoria	Hospitality	7
8			Courtyard Estates of Kewanee	Kewanee	Petersen Restaurants, LLC	Peoria	Restaurant	8
9			Courtyard Estates of Bradford	Bradford	Petersen Health Care IV, LLC	Peoria	Mgmt/Bookkeeping	9
10			Courtyard Estates of Galva	Galva	Petersen Health Care V, LLC	Peoria	Mgmt/Bookkeeping	10
11			Courtyard Estates of Walcott	Walcott	Petersen Health Care VI, LLC	Peoria	Mgmt/Bookkeeping	11
12			Courtyard Village of Kewanee	Kewanee	Petersen Health Care VII, LLC	Sullivan	Lessor	12
13			Lakewood Village	Charleston	Petersen Health Care VIII, LLC	Peoria	Mgmt/Bookkeeping	13
14			Courtyard Estates of Monmouth	Monmouth	Petersen Health Care X, LLC	Peoria	Lessor	14
15			Riverview Estates	Havana	Petersen Osage Beach, LLC	Osage Beach, MO	Lessor	15
16			Simple Blessings	Casey	Petersen West Frankfort, LLC	West Frankfort	Lessor	16
17			Courtyard Estates of Bushnell	Bushnell	Midwest Health Care, LLC	Peoria	Mgmt/Bookkeeping	17
18			Courtyard Estates of Canton	Canton	Poplar Bluff Health Care, LLC	Poplar Bluff, MO	Lessor	18
19			Legacy Estates of Monmouth	Monmouth	Petersen Roseville, LLC	Roseville	Lessor	19
20			Courtyard Estates of Sullivan	Sullivan				20
21			Courtyard Estates of Peoria	Peoria				21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

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	N/A										3
4											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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1	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	1,542,131	77	\$ 311,109	\$ 308,619	18,960	\$ 3,825	1
2	2	Food	Resident Days	1,542,131	77	1,436	0	18,960	18	2
3	3	Housekeeping	Resident Days	1,542,131	77	2,014	0	18,960	25	3
4	4	Laundry	Resident Days	1,542,131	77	0	0	18,960	0	4
5	5	Utilities	Resident Days	1,542,131	77	20,347	0	18,960	250	5
6	6	Maintenance	Resident Days	1,542,131	77	126,852	100,385	18,960	1,560	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,542,131	77	70,933	0	18,960	872	7
8	10	Nursing and Medical Records	Resident Days	1,542,131	77	3,130	0	18,960	38	8
9	10A	Therapy	Resident Days	1,542,131	77	0	0	18,960	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,542,131	77	0	0	18,960	0	10
11	17	Administrative	Resident Days	1,542,131	77	4,905,497	4,905,497	18,960	56,975	11
12	19	Professional Services	Resident Days	1,542,131	77	355,921	0	18,960	4,376	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,542,131	77	25,013	0	18,960	308	13
14	21	Clerical and General Office	Resident Days	1,542,131	77	2,900,214	2,467,442	18,960	35,657	14
15	23	Inservice Training & Education	Resident Days	1,542,131	77	10,374	0	18,960	128	15
16	24	Travel and Seminar	Resident Days	1,542,131	77	3,057	0	18,960	38	16
17	25	Other Admin. Staff Transport.	Resident Days	1,542,131	77	266,518	0	18,960	3,277	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,542,131	77	72,152	0	18,960	887	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,542,131	77	1,178,815	0	18,960	14,493	19
20	30	Depreciation	Resident Days	1,542,131	77	416,712	0	18,960	5,123	20
21	32	Interest	Resident Days	1,542,131	77	501,565	0	18,960	6,167	21
22	33	Real Estate Taxes	Resident Days	1,542,131	77	25,635	0	18,960	315	22
23	34	Rent-Facility and Grounds	Resident Days	1,542,131	77	0	0	18,960	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,542,131	77	45,440	0	18,960	559	24
25	TOTALS					\$ 11,242,734	\$ 7,781,943		\$ 134,891	25

Facility Name & ID Number Pleasant View Rehab & Health Care # 0050203 Report Period Beginning: 1/1/2011 Ending: 2/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1	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	49,943	2	\$	\$	18,960	\$	1
2	2	Food	Resident Days	49,943	2			18,960		2
3	3	Housekeeping	Resident Days	49,943	2			18,960		3
4	4	Laundry	Resident Days	49,943	2			18,960		4
5	5	Utilities	Resident Days	49,943	2			18,960		5
6	6	Maintenance	Resident Days	49,943	2			18,960		6
7	7	Mgmt. Allocation of Benefits	Resident Days	49,943	2			18,960		7
8	10	Nursing and Medical Records	Resident Days	49,943	2			18,960		8
9	10A	Therapy	Resident Days	49,943	2			18,960		9
10	15	Mgmt. Allocation of Benefits	Resident Days	49,943	2			18,960		10
11	17	Administrative	Resident Days	49,943	2			18,960		11
12	19	Professional Services	Resident Days	49,943	2	6,565		18,960	2,492	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	49,943	2			18,960		13
14	21	Clerical and General Office	Resident Days	49,943	2	9,450		18,960	3,588	14
15	23	Inservice Training & Education	Resident Days	49,943	2			18,960		15
16	24	Travel and Seminar	Resident Days	49,943	2			18,960		16
17	25	Other Admin. Staff Transport.	Resident Days	49,943	2			18,960		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	49,943	2			18,960		18
19	27	Mgmt. Allocation of Benefits	Resident Days	49,943	2			18,960		19
20	30	Depreciation	Resident Days	49,943	2			18,960		20
21	32	Interest	Resident Days	49,943	2			18,960		21
22	33	Real Estate Taxes	Resident Days	49,943	2			18,960		22
23	34	Rent-Facility and Grounds	Resident Days	49,943	2			18,960		23
24	35	Rent-Equipment & Vehicles	Resident Days	49,943	2			18,960		24
25	TOTALS					\$ 16,015	\$		\$ 6,080	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	4/1/09	\$ 1,725,000	\$ 1,648,318	3/25/12	0.0675	\$ 112,296	1
2												2
3								Interest Income Offset			(32)	3
4								Home Office Allocation-PHC			6,167	4
5												5
	Working Capital											
6	First Merit		X	LOC	Varies	4/1/09	400,000	279,000	3/25/12	Varies	7,234	6
7												7
8												8
9	TOTAL Facility Related						\$ 2,125,000	\$ 1,927,318			\$ 125,665	9
	B. Non-Facility Related*											
10								Amortization Expense			13,569	10
11								IDES Interest			3,395	11
12								Disallowed IDES Interest			(3,395)	12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ 13,569	14
15	TOTALS (line 9+line14)						\$ 2,125,000	\$ 1,927,318			\$ 139,234	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.)

HFS 3745 (N-4-99)

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 2010 report.		\$	39,700	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.)	2010	\$	38,993	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(707)	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	40,200	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. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	315	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	39,808	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2006		8
	2007		9
	2008	36,622	10
	2009	38,516	11
	2010	38,993	12

Accrual based on prior year tax bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	\$	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.

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Pleasant View Rehab & Health Care

COUNTY

Whiteside

FACILITY IDPH LICENSE NUMBER

0050203

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 2010 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 2010.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>09-17-130-001</u>	<u>Long-Term Care Facility</u>	\$ <u>38,992.98</u>	\$ <u>38,992.98</u>
2. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
TOTALS		\$ <u><u>38,992.98</u></u>	\$ <u><u>38,992.98</u></u>

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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

X. BUILDING AND GENERAL INFORMATION:

- A. Square Feet: 23,743
- B. General Construction Type: Exterior Brick Frame Metal Number of Stories 1
- C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)
- D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)
- E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

- F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	23,743	2009	\$ 183,000	1
2					2
3	TOTALS	23,743		\$ 183,000	3

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	74		2009	1974	\$ 992,911	\$	25	\$ 39,716	\$ 39,716	\$ 99,290	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Drain Line Repair			2010	2,567		7	366	366	549	9
10	Fire Alarm Panel			2010	3,300		7	471	471	942	10
11	Water Softener			2011	3,415		7	244	244	244	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	Building Improvement Booked					1,326			(1,326)		30
31											31
32	2011-Home Office Allocation-Building Improvements				9,024			216	216		32
33	2011-Home Office Allocation-Land Improvements				842			54	54		33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,012,059	\$ 1,326		\$ 41,067	\$ 39,741	\$ 101,025	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	\$291,678	\$1,668	\$41,447	\$39,779	7-10 yrs.	\$103,102	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Home Office Allocation			11,203	11,203			74
75	TOTALS	\$291,678	\$1,668	\$52,650	\$50,982		\$103,102	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$1,486,737	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$2,994	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$93,717	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$90,723	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$204,127	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					87
88	N/A				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: \$ 3,456 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			\$	\$	17
18			N/A		18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:
Beginning
Ending
11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent
12. /2012 \$
13. /2013 \$
14. /2014 \$

* 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.

Pleasant View Rehab & Health Care
0050203

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

Schedule 14A

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

Medical Equipment	\$	1,000
Dishwasher		-
Laundry Equipment		-
Copier		1,897
Home Office Allocation		559
		<u>3,456</u>
		<u><u>3,456</u></u>

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

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	☐ YES ☒ NO	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	\$	3,539	\$ 53,089	\$	3,539	\$ 53,089	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,051	15,764		1,051	15,764	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		4,687	70,301		4,687	70,301	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				66,105		66,105	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			\$	9,277	\$ 139,154	\$ 66,105	9,277	\$ 205,259	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.

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 386,240	\$ 386,240	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 10,000)	595,502	595,502	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	20,753	20,753	6
7	Other Prepaid Expenses	211,916	211,916	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Intercompany-PC III	284,593		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,499,004	\$ 1,214,411	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		183,000	13
14	Buildings, at Historical Cost		1,001,935	14
15	Leasehold Improvements, at Historical Cost	9,282	10,124	15
16	Equipment, at Historical Cost	11,678	291,678	16
17	Accumulated Depreciation (book methods)	(5,373)	(204,127)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe Goodwill		650,000	22
23	Other(specify): Loan Costs		3,393	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 15,587	\$ 1,936,003	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,514,591	\$ 3,150,414	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 394,445	\$ 394,445	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	279,000	279,000	29
30	Accrued Salaries Payable	79,774	79,774	30
	Accrued Taxes Payable (excluding real estate taxes)	6,473	6,473	31
32	Accrued Real Estate Taxes(Sch.IX-B)		40,200	32
33	Accrued Interest Payable	1,303	1,303	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	56,049	56,049	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 817,044	\$ 857,244	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,648,318	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 1,648,318	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 817,044	\$ 2,505,562	46
47	TOTAL EQUITY(page 18, line 24)	\$ 697,547	\$ 644,852	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,514,591	\$ 3,150,414	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 528,306	1
2	Restatements (describe):		2
3	Rounding	(1)	3
4	2010 Bad Debt Allowance entered after CR was completed	15,000	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 543,305	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	154,242	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)	\$ 154,242	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)	\$ 697,547	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Pleasant View Rehab & Health Care

0050203

Report Period Beginning: 1/1/2011

Ending: 12/31/2011

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			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,531,102	1
2	Discounts and Allowances for all Levels	(126,596)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,404,506	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	214,718	6
7	Oxygen	146	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 214,864	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	5,661	14
15	Telephone, Television and Radio	5,043	15
16	Rental of Facility Space	101	16
17	Sale of Drugs	95,038	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	8,266	20
21	Other Medical Services	1,834	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 115,943	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	32	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 32	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	707	28
28a	Transportation Revenue	5,532	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 6,239	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,741,584	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	532,017	31
32	Health Care	1,233,083	32
33	General Administration	457,436	33
	B. Capital Expense		
34	Ownership	199,759	34
	C. Ancillary Expense		
35	Special Cost Centers	124,532	35
36	Provider Participation Fee	40,515	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,587,342	40
41	Income before Income Taxes (line 30 minus line 40)**	154,242	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 154,242	43

* 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. Facility is part of larger entity.

*** 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	1,832	2,013	\$ 58,185	\$ 28.90	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,302	6,528	167,912	25.72	3
4	Licensed Practical Nurses	9,667	10,340	232,163	22.45	4
5	CNAs & Orderlies	38,652	41,588	420,368	10.11	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,076	2,129	25,052	11.77	9
10	Activity Assistants	1,447	1,499	12,552	8.37	10
11	Social Service Workers	1,753	1,889	28,081	14.87	11
12	Dietician					12
13	Food Service Supervisor	2,091	2,236	29,343	13.12	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,263	12,841	110,574	8.61	15
16	Dishwashers					16
17	Maintenance Workers	3,055	3,130	44,438	14.20	17
18	Housekeepers	7,491	7,658	64,248	8.39	18
19	Laundry	3,278	3,354	28,109	8.38	19
20	Administrator	2,080	2,080	56,975	27.39	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,967	2,082	25,340	12.17	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) See Sch 20A	3,715	3,805	74,433	19.56	33
34	TOTAL (lines 1 - 33)	97,669	103,172	\$ 1,377,773 *	\$ 13.35	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	24,200	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,427	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	Monthly	4,060	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 31,687		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	13	\$ 521	L10, C3	50
51	Licensed Practical Nurses	125	3,488	L10, C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	138	\$ 4,009		53

Pleasant View Rehab & Health Care

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

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	1,868	1,958	44,741	22.85
Transportation	27	27	292	10.81
Marketing	1,820	1,820	29,400	16.15
TOTAL	3,715	3,805	74,433	

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
Danielle Vance	Administrator	0	\$ 56,975	Workers' Compensation Insurance		\$ 22,293	IDPH License Fee	\$ 3,980
				Unemployment Compensation Insurance		34,467	Advertising: Employee Recruitment	5,730
				FICA Taxes		84,003	Health Care Worker Background Check	
				Employee Health Insurance		29,644	(Indicate # of checks performed)	
				Employee Meals			Patient Background Checks	105 1,058
				Illinois Municipal Retirement Fund (IMRF)*			Miscellaneous Licenses & Permits	158
				Employee Relations		1,087	Miscellaneous Dues & Subscriptions	480
							Home Office Allocation	308
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)								
			\$ 56,975					
B. Administrative - Other								
Description			Amount					
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 195,300				Less: Public Relations Expense	(450)
							Non-allowable advertising	()
							Yellow page advertising	()
TOTAL (agree to Schedule V, line 17, col. 3)				TOTAL (agree to Schedule V,		\$ 171,494	TOTAL (agree to Sch. V,	\$ 11,264
(Attach a copy of any management service agreement)				line 22, col.8)			line 20, col. 8)	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
E-Health Data Solutions	Computer Services		\$ 3,420				Out-of-State Travel	\$
Honkamp Krueger & Co.	Accounting Fees		336					
Mediacom	Computer Services		1,317	N/A				
							In-State Travel	
							Seminar Expense	
							Home Office Allocation	38
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V,	
(If total legal fees exceed \$5,000, attach copy of invoices.)							line 24, col. 8)	\$ 38
			\$ 5,073					

* Attach copy of IMRF notifications

**See instructions.

Pleasant View Rehab & Health Care
0050203
Period Beginning 1/1/2011
Period End 12/31/2011

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		5,073
Home Office Allocation		
Heyl, Royster, Voelker & Allen	Legal	4
Henry County Recorder	Legal	-
Ginoli & Company	Accountants	608
Miscellaneous Vendors	Computer Services	50
Advanced Answers on Demand	Computer Services	2,538
Access 2 Go	Computer Services	250
Kemper Technology	Computer Services	116
MediFax	Computer Services	39
VisionShare/Ability Network	Computer Services	179
Advanced System Design	Computer Services	234
Simple LTC	Computer Services	293
Optimizer Systems	Other Prof Fees	30
Clifton Gunderson	Other Prof Fees	10
Mike Miller	Other Prof Fees	14
OIC Group	Other Prof Fees	3
AllScripts	Other Prof Fees	8
Law Offices of Abraham Gutnicki	Legal	569
Ginoli & Company	Accountants	1,923
Total (agree to Schedule V, line 19, column 8)		<u>11,941</u>

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 13,519 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. \$ 40,515
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? N/A 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 benefit: on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 5,661

(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. \$ 91
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? Adequate records have been maintained.
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A

(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? N/A
Attach invoices and a summary of services for all architect and appraisal fees