

		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: 0047621

Facility Name: South Elgin Rehabilitation & Health Care Center

Address: 746 West Spring Street South Elgin 60177
Number City Zip Code

County: Kane

Telephone Number: (847) 697-0565 Fax # (847) 697-0568

HFS ID Number:

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

Type of Ownership:

VOLUNTARY,NON-PROFIT

Charitable Corp.

Trust

IRS Exemption Code

X

PROPRIETARY

Individual

Partnership

Corporation

"Sub-S" Corp.

X

Limited Liability Co.

Trust

Other

GOVERNMENTAL

State

County

Other

In the event there are further questions about this report, please contact:
Name: 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)

(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 South Elgin Rehabilitation & Health Care Center

0047621 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	14	14	5,110	1
2	Skilled Pediatric (SNF/PED)			2
3	76	76	27,740	3
4	Intermediate/DD			4
5	Sheltered Care (SC)			5
6	ICF/DD 16 or Less			6
7	90	90	32,850	7
	TOTALS			

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			2,144	2,144	8
9	SNF/PED					9
10	ICF	19,561	3,094		22,655	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,561	3,094	2,144	24,799	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.49%

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 10/1/2005

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 10/1/2005 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter number of beds certified 14 and days of care provided 2,134

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 South Elgin Rehabilitation & Health Care Ce # 0047621 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 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	129,257	11,406		140,663		140,663	5,003	145,666			1
2	Food Purchase		139,741		139,741		139,741	(31)	139,710			2
3	Housekeeping	141,267	23,546		164,813		164,813	32	164,845			3
4	Laundry	16,403	7,428		23,831		23,831		23,831			4
5	Heat and Other Utilities			62,243	62,243		62,243	327	62,570			5
6	Maintenance	44,636	8,131	27,892	80,659		80,659	2,040	82,699			6
7	Other (specify):* <u>Home Off. Ben. All.</u>							1,141	1,141			7
8	TOTAL General Services	331,563	190,252	90,135	611,950		611,950	8,512	620,462			8
	B. Health Care and Programs											
9	Medical Director			14,400	14,400		14,400		14,400			9
10	Nursing and Medical Records	1,344,624	123,789	15,703	1,484,116		1,484,116	(1,560)	1,482,556			10
10a	Therapy		48	872,012	872,060		872,060		872,060			10a
11	Activities	34,992	191	549	35,732		35,732	(5,970)	29,762			11
12	Social Services	39,160	15		39,175		39,175		39,175			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	1,418,776	124,043	902,664	2,445,483		2,445,483	(7,530)	2,437,953			16
	C. General Administration											
17	Administrative			413,400	413,400		413,400	(318,400)	95,000			17
18	Directors Fees											18
19	Professional Services			4,955	4,955		4,955	6,902	11,857			19
20	Dues, Fees, Subscriptions & Promotions			3,540	3,540		3,540	402	3,942			20
21	Clerical & General Office Expenses	31,091	5,686	9,694	46,471		46,471	47,848	94,319			21
22	Employee Benefits & Payroll Taxes			223,839	223,839		223,839		223,839			22
23	Inservice Training & Education			(192)	(192)		(192)	167	(25)			23
24	Travel and Seminar							49	49			24
25	Other Admin. Staff Transportation			4,731	4,731		4,731	4,286	9,017			25
26	Insurance-Prop.Liab.Malpractice			29,716	29,716		29,716	1,160	30,876			26
27	Other (specify):* <u>Home Off. Ben. All.</u>							18,957	18,957			27
28	TOTAL General Administration	31,091	5,686	689,683	726,460		726,460	(238,629)	487,831			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,781,430	319,981	1,682,482	3,783,893		3,783,893	(237,647)	3,546,246			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			29,240	29,240		29,240	6,422	35,662			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			37,721	37,721		37,721	53,929	91,650			32
33	Real Estate Taxes			39,919	39,919		39,919	412	40,331			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			18,320	18,320		18,320	731	19,051			35
36	Other (specify):*											36
37	TOTAL Ownership			125,200	125,200		125,200	61,494	186,694			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		91,710		91,710		91,710		91,710			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			49,275	49,275		49,275		49,275			42
43	Other (specify):* Non-allowable Costs	28,285	699	262,114	291,098		291,098	(291,098)				43
44	TOTAL Special Cost Centers	28,285	92,409	311,389	432,083		432,083	(291,098)	140,985			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,809,715	412,390	2,119,071	4,341,176		4,341,176	(467,251)	3,873,925			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	(54)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,894)	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	(480)	30		9
10	Interest and Other Investment Income	(798)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(6)	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	(604)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(246,986)	43		24
25	Fund Raising, Advertising and Promotional	(33,253)	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 <u>See Page 5A</u>	(14,309)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (300,384)		\$	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)	(166,867)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (166,867)		36
	(sum of SUBTOTALS)			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (467,251)		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

ID#0047621

Report Period Beginning:1/1/2011

Ending:12/31/2011

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (8,134)	43	1
2	X-Rays-Part A	2,411	43	2
3	Offset Transportation Revenue	(5,970)	11	3
4	Offset Nursing Supplies Revenue	(1,610)	10	4
5	Offset Miscellaneous Office Supplies Revenue	(374)	21	5
6	Disallowed Special Events	(632)	43	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(14,309)		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		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)	
1	V	1	Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 5,003	\$ 5,003	1
2	V	2	Food		Petersen Health Care, Inc.	100.00%	23	23	2
3	V	3	Housekeeping		Petersen Health Care, Inc.	100.00%	32	32	3
4	V	4	Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5	Utilities		Petersen Health Care, Inc.	100.00%	327	327	5
6	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	2,040	2,040	6
7	V	7	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,141	1,141	7
8	V	10	Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	50	50	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	413,400	Petersen Health Care, Inc.	100.00%	95,000	(318,400)	11
12	V	19	Professional Services		Petersen Health Care, Inc.	100.00%	5,724	5,724	12
13	V								13
14	Total			\$ 413,400			\$ 109,340	\$ * (304,060)	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%	\$ 402	\$ 402	15
16	V	21	Clerical and General Office		Petersen Health Care, Inc.	100.00%	46,638	46,638	16
17	V	23	Inservice Training & Education		Petersen Health Care, Inc.	100.00%	167	167	17
18	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	49	49	18
19	V	25	Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	4,286	4,286	19
20	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	1,160	1,160	20
21	V	27	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	18,957	18,957	21
22	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	6,701	6,701	22
23	V	32	Interest		Petersen Health Care, Inc.	100.00%	8,066	8,066	23
24	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	412	412	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%	731	731	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			\$			\$ 87,569	\$ * 87,569	39

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

VII. RELATED PARTIES (continued)

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

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	\$	Petersen Health Operations, LLC	100.00%	\$ 0	\$	15
16	V	2	Food		Petersen Health Operations, LLC	100.00%	0		16
17	V	3	Housekeeping		Petersen Health Operations, LLC	100.00%	0		17
18	V	4	Laundry		Petersen Health Operations, LLC	100.00%	0		18
19	V	5	Utilities		Petersen Health Operations, LLC	100.00%	0		19
20	V	6	Maintenance		Petersen Health Operations, LLC	100.00%	0		20
21	V	7	Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	0		21
22	V	10	Nursing and Medical Records		Petersen Health Operations, LLC	100.00%	0		22
23	V	12	Social Services		Petersen Health Operations, LLC	100.00%	0		23
24	V	17	Administrative		Petersen Health Operations, LLC	100.00%	0		24
25	V	19	Professional Services		Petersen Health Operations, LLC	100.00%	1,178	1,178	25
26	V	20	Dues, Fees, Subs & Promotions		Petersen Health Operations, LLC	100.00%	0		26
27	V	21	Clerical and General Office		Petersen Health Operations, LLC	100.00%	1,584	1,584	27
28	V	22	Employee Benefits & Payroll		Petersen Health Operations, LLC	100.00%	0		28
29	V	23	Inservice Training & Education		Petersen Health Operations, LLC	100.00%	0		29
30	V	24	Travel and Seminar		Petersen Health Operations, LLC	100.00%	0		30
31	V	25	Other Admin. Staff Transport.		Petersen Health Operations, LLC	100.00%	0		31
32	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Operations, LLC	100.00%	0		32
33	V	27	Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	0		33
34	V	30	Depreciation		Petersen Health Operations, LLC	100.00%	201	201	34
35	V	32	Interest		Petersen Health Operations, LLC	100.00%	46,661	46,661	35
36	V	33	Real Estate Taxes		Petersen Health Operations, LLC	100.00%	0		36
37	V	34	Rent-Facility and Grounds		Petersen Health Operations, LLC	100.00%	0		37
38	V	35	Rent-Equipment & Vehicles		Petersen Health Operations, LLC	100.00%	0		38
39	Total			\$			\$ 49,624	\$ * 49,624	39

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

Facility Name & ID Number South Elgin Rehabilitation & Health Care Center# 0047621

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	Petersen Companies, L	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 System	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 V	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Care V	Peoria	Mgmt/Bookkeeping	11
12			Countryview Terrace	Louisville	Petersen Health Care V	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care V	Peoria	Mgmt/Bookkeeping	13
14			Decatur Rehab & Health Care Center	Decatur	Petersen Health Care X	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 Ca	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 South Elgin Rehabilitation & Health Care Center# 0047621

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 South Elgin Rehabilitation & Health Care Center# 0047621

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			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

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											4
5											5
6	N/A										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 South Elgin Rehabilitation & Health Care Center # 0047621 Report Period Beginning: 1/1/2011 Ending: 2/31/2011

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	24,799	\$ 5,003	1
2	2	Food	Resident Days	1,542,131	77	1,436	0	24,799	23	2
3	3	Housekeeping	Resident Days	1,542,131	77	2,014	0	24,799	32	3
4	4	Laundry	Resident Days	1,542,131	77	0	0	24,799	0	4
5	5	Utilities	Resident Days	1,542,131	77	20,347	0	24,799	327	5
6	6	Maintenance	Resident Days	1,542,131	77	126,852	100,385	24,799	2,040	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,542,131	77	70,933	0	24,799	1,141	7
8	10	Nursing and Medical Records	Resident Days	1,542,131	77	3,130	0	24,799	50	8
9	10A	Therapy	Resident Days	1,542,131	77	0	0	24,799	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,542,131	77	0	0	24,799	0	10
11	17	Administrative	Resident Days	1,542,131	77	4,905,497	4,905,497	24,799	95,000	11
12	19	Professional Services	Resident Days	1,542,131	77	355,921	0	24,799	5,724	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,542,131	77	25,013	0	24,799	402	13
14	21	Clerical and General Office	Resident Days	1,542,131	77	2,900,214	2,467,442	24,799	46,638	14
15	23	Inservice Training & Education	Resident Days	1,542,131	77	10,374	0	24,799	167	15
16	24	Travel and Seminar	Resident Days	1,542,131	77	3,057	0	24,799	49	16
17	25	Other Admin. Staff Transport.	Resident Days	1,542,131	77	266,518	0	24,799	4,286	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,542,131	77	72,152	0	24,799	1,160	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,542,131	77	1,178,815	0	24,799	18,957	19
20	30	Depreciation	Resident Days	1,542,131	77	416,712	0	24,799	6,701	20
21	32	Interest	Resident Days	1,542,131	77	501,565	0	24,799	8,066	21
22	33	Real Estate Taxes	Resident Days	1,542,131	77	25,635	0	24,799	412	22
23	34	Rent-Facility and Grounds	Resident Days	1,542,131	77	0	0	24,799	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,542,131	77	45,440	0	24,799	731	24
25	TOTALS					\$ 11,242,734	\$ 7,781,943		\$ 196,909	25

Facility Name & ID Number South Elgin Rehabilitation & Health Care Center # 0047621 Report Period Beginning: 1/1/2011 Ending: 2/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

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

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	402,040	21	\$	\$	24,799	\$	1
2	2	Food	Resident Days	402,040	21			24,799		2
3	3	Housekeeping	Resident Days	402,040	21			24,799		3
4	4	Laundry	Resident Days	402,040	21			24,799		4
5	5	Utilities	Resident Days	402,040	21			24,799		5
6	6	Maintenance	Resident Days	402,040	21			24,799		6
7	7	Mgmt. Allocation of Benefits	Resident Days	402,040	21			24,799		7
8	10	Nursing and Medical Records	Resident Days	402,040	21			24,799		8
9	12	Social Services	Resident Days	402,040	21			24,799		9
10	17	Administrative	Resident Days	402,040	21			24,799		10
11	19	Professional Services	Resident Days	402,040	21	19,096		24,799	1,178	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	402,040	21			24,799		12
13	21	Clerical and General Office	Resident Days	402,040	21	25,677		24,799	1,584	13
14	22	Employee Benefits & Payroll	Resident Days	402,040	21			24,799		14
15	23	Inservice Training & Education	Resident Days	402,040	21			24,799		15
16	24	Travel and Seminar	Resident Days	402,040	21			24,799		16
17	25	Other Admin. Staff Transport.	Resident Days	402,040	21			24,799		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	402,040	21			24,799		18
19	27	Mgmt. Allocation of Benefits	Resident Days	402,040	21			24,799		19
20	30	Depreciation	Resident Days	402,040	21	3,263		24,799	201	20
21	32	Interest	Resident Days	402,040	21	756,464		24,799	46,661	21
22	33	Real Estate Taxes	Resident Days	402,040	21			24,799		22
23	34	Rent-Facility and Grounds	Resident Days	402,040	21			24,799		23
24	35	Rent-Equipment & Vehicles	Resident Days	402,040	21			24,799		24
25	TOTALS					\$ 804,500	\$		\$ 49,624	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE												
A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)												
	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Bank of America		X	Mortgage	Varies	1/19/07	\$ 750,000	\$ 710,267	12/31/13	Varies	\$ 37,721	1
2												2
3								Interest Income Offset			(798)	3
4								Home Office Allocation-PHC			8,066	4
5								Home Office Allocation-PHO			46,661	5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$ 750,000	\$ 710,267			\$ 91,650	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 750,000	\$ 710,267			\$ 91,650	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

1. Real Estate Tax accrual used on 2010 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	36,300	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		\$	37,519	2
3. Under or (over) accrual (line 2 minus line 1).				\$	1,219	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	38,700	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.)			Home Office Allocation		412	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	40,331	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2006	56,994	8		
		2007	56,174	9		
		2008	56,782	10		
		2009	35,225	11		
		2010	37,519	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 South Elgin Rehabilitation & Health Care Center COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0047621

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>06-34-226-014</u>	<u>Long-Term Care Facility</u>	\$ <u>37,518.74</u>	\$ <u>37,518.74</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>37,518.74</u></u>	\$ <u><u>37,518.74</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: 15,169
- B. General Construction Type: Exterior Brick Frame Wood 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	131,116	2005	\$ 467,500	1
2					2
3	TOTALS	131,116		\$ 467,500	3

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	93		2005	1970	\$ ***	\$		\$		\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Wheelchair			2006	15,515		25	621	621	3,415	9
10	Backflow Prevention			2006	14,325		25	573	573	3,152	10
11	Walls			2006	3,550		25	142	142	781	11
12	7 Rooms-Floor Replacement, Painting, Wallpaper, Trim Labor			2007	10,400		20	520	520	2,340	12
13	7 Rooms-Floor Tile, Sink, Supplies, Paint, Wallpaper			2007	5,100		20	255	255	1,148	13
14	Fire Sprinkler System Repair			2008	2,580		15	172	172	602	14
15	Dry Pipe Valve Accelerator Replacement			2008	8,436		15	562	562	1,967	15
16	Sprinkler System Repairs			2008	5,156		15	344	344	1,204	16
17	Water Line Repairs			2008	6,969		15	464	464	1,624	17
18	Sprinkler System Replacement			2009	27,836		20	1,392	1,392	3,480	18
19	Pendant Sprinkler System			2010	5,462		7	780	780	1,170	19
20	Water Heater			2011	5,120		7	366	366	366	20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28	*** Note:										28
29	Facility was purchased as part of a multi-facility										29
30	sale. For purposes of allocating the purchase										30
31	price, appraisers valued the building and land										31
32	at the value of the bare land only. The allocated										32
33	amount appears on page 11 (Sch XI (A) line 1, column 4).										33
34	2011-Home Office Allocation-Building Improvements										34
35											35
36											36

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

See Page 12A, Line 70 for total

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

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	Land Improvements Booked								60
61	Building Booked								61
62	Building Improvement Booked			5,532			(5,532)		62
63									63
64									64
65	2011-Home Office Allocation-Land Improvements		1,102			70	70		65
66	2011-Home Office Allocation-Building Improvements		11,803			283	283		66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 123,354	\$ 5,532		\$ 6,544	\$ 1,012	\$ 21,249	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	\$ 167,114	\$ 22,713	\$ 22,105	\$ (608)	5-10 yrs.	\$ 130,387	71
72	Current Year Purchases	9,286	995	464	(531)	10 yrs.	464	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			6,549	6,549			74
75	TOTALS	\$ 176,400	\$ 23,708	\$ 29,118	\$ 5,410		\$ 130,851	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets			1	2
		Reference	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 767,254	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 29,240	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 35,662	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 6,422	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 152,100	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		\$	\$	\$
87				
88	N/A			
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93	N/A	
94		
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: \$ 12,113
- 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	2006 Ford E250	\$ 578.17	\$ 6,938	17
18					18
19					19
20					20
21	TOTAL		\$ 578.17	\$ 6,938	21

10. Effective dates of current rental agreement:
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.

South Elgin Rehabilitation & Health Care Center
0047621

Period Beginning	<u>1/1/2011</u>
Period End	<u>12/31/2011</u>

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$ 4,212
Dishwasher	708
Laundry Equipment	-
Copier	6,462
Home Office Allocation	<u>731</u>
	<u>12,113</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	\$	21,532	\$ 322,974	\$	21,532	\$ 322,974	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		6,385	95,776		6,385	95,776	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		30,188	452,822	48	30,188	452,870	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 prescripts				91,710		91,710	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Respiratory Therapy	10A(3)			29	440		29	440	13
14	TOTAL			\$	58,134	\$ 872,012	\$ 91,758	58,134	\$ 963,770	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	\$ 1,656,266	\$ 1,656,266	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 260,000)	1,940,068	1,940,068	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	25,125	25,125	6
7	Other Prepaid Expenses	12,521	12,521	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Other Prepaid Expenses	1,576	1,576	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,635,556	\$ 3,635,556	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		467,500	13
14	Buildings, at Historical Cost	467,500	11,803	14
15	Leasehold Improvements, at Historical Cost	98,324	111,551	15
16	Equipment, at Historical Cost	176,400	176,400	16
17	Accumulated Depreciation (book methods)	(166,085)	(152,100)	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)	\$ 576,139	\$ 615,154	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,211,695	\$ 4,250,710	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 813,743	\$ 813,743	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	36,686	36,686	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,537	5,537	31
32	Accrued Real Estate Taxes(Sch.IX-B)	38,700	38,700	32
33	Accrued Interest Payable	3,718	3,718	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	41,792	41,792	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 940,176	\$ 940,176	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	710,267	710,267	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)	\$ 710,267	\$ 710,267	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,650,443	\$ 1,650,443	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,561,252	\$ 2,600,267	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,211,695	\$ 4,250,710	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1	
		Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,770,726	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,770,726	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	790,526	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)	\$ 790,526	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)	\$ 2,561,252	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number South Elgin Rehabilitation & Health Care Center # 0047621 Report Period Beginning: 1/1/2011Ending: 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**

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,835,489	1
2	Discounts and Allowances for all Levels	(35,918)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,799,571	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,159,677	6
7	Oxygen	973	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,160,650	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	54	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	145,917	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	13,338	20
21	Other Medical Services	3,420	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 162,729	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	798	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 798	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	1,984	28
28a	Transportation Revenue	5,970	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 7,954	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,131,702	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	611,950	31
32	Health Care	2,445,483	32
33	General Administration	726,460	33
	B. Capital Expense		
34	Ownership	125,200	34
	C. Ancillary Expense		
35	Special Cost Centers	382,808	35
36	Provider Participation Fee	49,275	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,341,176	40
41	Income before Income Taxes (line 30 minus line 40)**	790,526	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 790,526	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	2,228	2,228	\$ 71,069	\$ 31.90	1
2	Assistant Director of Nursing	1,733	1,733	50,827	29.33	2
3	Registered Nurses	14,607	15,180	478,907	31.55	3
4	Licensed Practical Nurses	5,659	5,741	148,935	25.94	4
5	CNAs & Orderlies	41,781	42,798	483,002	11.29	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,877	1,877	25,424	13.55	9
10	Activity Assistants	1,177	1,177	9,568	8.13	10
11	Social Service Workers	2,080	2,080	39,160	18.83	11
12	Dietician					12
13	Food Service Supervisor	2,153	2,153	25,766	11.97	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,000	10,448	103,491	9.91	15
16	Dishwashers					16
17	Maintenance Workers	2,879	2,943	44,636	15.17	17
18	Housekeepers	16,184	16,782	141,267	8.42	18
19	Laundry	1,840	1,959	16,403	8.37	19
20	Administrator	2,080	2,080	95,000	45.67	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,084	2,084	31,091	14.92	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	2,246	2,246	36,810	16.39	31
32	Other Health Care: Care Plan Coord.	2,044	2,124	75,074	35.35	32
33	Other(specify) Marketing	1,786	1,786	28,285	15.84	33
34	TOTAL (lines 1 - 33)	114,438	117,419	\$ 1,904,715 *	\$ 16.22	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	14,400	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,505	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 18,905		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	135	\$ 4,412	L10, C3	50
51	Licensed Practical Nurses	202	6,744	L10, C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	337	\$ 11,156		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name	Function	%	Amount	Description		Amount	Description		Amount		
Mary Karson	Administrator	0	\$ 95,000	Workers' Compensation Insurance		\$ 30,645	IDPH License Fee		\$		
				Unemployment Compensation Insurance		36,766	Advertising: Employee Recruitment		461		
				FICA Taxes		135,962	Health Care Worker Background Check				
				Employee Health Insurance		17,764	(Indicate # of checks performed)				
				Employee Meals			Patient Background Checks		225 2,256		
				Illinois Municipal Retirement Fund (IMRF)*			Miscellaneous Licenses & Permits		823		
				Employee Relations		1,556	Miscellaneous Dues & Subscriptions		0		
				Employee Retirement		1,244					
				Life Insurance		(98)	Home Office Allocation		402		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)							Less: Public Relations Expense		()		
B. Administrative - Other							Non-allowable advertising		()		
							Yellow page advertising		()		
Description											
Management Fees-See Page 6, Eliminated on P 3, C 7							TOTAL (agree to Sch. V,		\$ 3,942		
							line 20, col. 8)				
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL (agree to Schedule V, line 22, col.8)		\$ 223,839					
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		\$ 3,485			\$	Out-of-State Travel	\$			
AT&T	Computer Services		452								
Nigro, Westfall, Gryska	Legal Services		368	N/A							
McHenry Co. Circuit Clerk	Legal Services		122				In-State Travel				
Comcast Cable	Computer Services		248								
Honkamp Kruger & Co.	Accounting Fees		280								
							Seminar Expense				
							Home Office Allocation	49			
							Entertainment Expense	()			
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				TOTAL		\$	(agree to Sch. V, line 24, col. 8)		\$ 49		

*** Attach copy of IMRF notifications**

****See instructions.**

South Elgin Rehabilitation & Health Care Center
0047621

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)		4,955
Home Office Allocation		
Heyl, Royster, Voelker & Allen	Legal	6
Henry County Recorder	Legal	1
Ginoli & Company	Accountants	1,973
Miscellaneous Vendors	Computer Services	63
Advanced Answers on Demand	Computer Services	3,320
Access 2 Go	Computer Services	326
Kemper Technology	Computer Services	152
MediFax	Computer Services	51
VisionShare	Computer Services	234
Advanced System Design	Computer Services	306
Simple LTC	Computer Services	384
Optimizer Systems	Other Prof Fees	39
Clifton Gunderson	Other Prof Fees	13
Mike Miller	Other Prof Fees	19
OIC Group	Other Prof Fees	5
All Scripts	Other Prof Fees	10
Total (agree to Schedule V, line 19, column 8)		<u>11,857</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													
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. \$ 32,276 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. \$ 49,275
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. \$ 54
- (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. \$ 312
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