

		FOR BHF USE					

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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: <u>0047910</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>White Oak Rehabilitation & Health Care Center</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2011</u> to <u>12/31/2011</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>1700 White Street</u> <u>Mt. Vernon</u> <u>62864</u>																									
Number City Zip Code																									
County: <u>Jefferson</u>																									
Telephone Number: <u>(618) 242-4075</u> Fax # <u>(618) 242-4092</u>																									
HFS ID Number: _____		<table><tr><td rowspan="2">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Type or Print Name) <u>Mark B. Petersen</u></td></tr><tr><td>(Title) <u>Chief Executive Officer</u></td></tr><tr><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Date) _____	Paid Preparer	(Type or Print Name) <u>Mark B. Petersen</u>	(Title) <u>Chief Executive Officer</u>	(Signed) _____	(Date) _____														
Officer or Administrator of Provider	(Signed) _____																								
	(Date) _____																								
Paid Preparer	(Type or Print Name) <u>Mark B. Petersen</u>																								
	(Title) <u>Chief Executive Officer</u>																								
	(Signed) _____																								
	(Date) _____																								
Date of Initial License for Current Owners: <u>03/01/2006</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☒ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td>_____</td></tr><tr><td></td><td>☐ Other _____</td><td>_____</td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☒ "Sub-S" Corp.	_____		☐ Limited Liability Co.	_____		☐ Trust	_____		☐ Other _____	_____
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	☐ Limited Liability Co.	_____																							
	☐ Trust	_____																							
	☐ Other _____	_____																							
In the event there are further questions about this report, please contact:		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																							
Name: <u>Larry Templin</u> Telephone Number: <u>(309) 689-5869</u>																									
Email Address: _____																									

Facility Name & ID Number White Oak Rehabilitation & Health Care Center

0047910 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	<u>65</u>	Skilled (SNF)	<u>65</u>	<u>23,725</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>65</u>	TOTALS	<u>65</u>	<u>23,725</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>11,185</u>	<u>2,956</u>	<u>4,994</u>	<u>19,135</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>11,185</u>	<u>2,956</u>	<u>4,994</u>	<u>19,135</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.65%

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 3/01/2006

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 3/01/2006 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 65 and days of care provided 4,663

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/11 Fiscal Year: 12/31/11

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

STATE OF ILLINOIS

Facility Name & ID Number

White Oak Rehabilitation & Health Care Center

#

0047910

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

Page 3

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	9	10	
1	Dietary	106,993	13,604		120,597		120,597	3,860	124,457			1
2	Food Purchase		117,976		117,976		117,976	(936)	117,040			2
3	Housekeeping	70,837	22,230	50	93,117		93,117	25	93,142			3
4	Laundry	26,987	10,963		37,950		37,950		37,950			4
5	Heat and Other Utilities			81,614	81,614		81,614	252	81,866			5
6	Maintenance	27,629	3,960	22,736	54,325		54,325	2,890	57,215			6
7	Other (specify):* Home Off. Ben. All.							880	880			7
8	TOTAL General Services	232,446	168,733	104,400	505,579		505,579	6,971	512,550			8
	B. Health Care and Programs											
9	Medical Director			9,000	9,000		9,000		9,000			9
10	Nursing and Medical Records	982,313	158,615	13,541	1,154,469		1,154,469	39	1,154,508			10
10a	Therapy	79,104	232	520,011	599,347		599,347		599,347			10a
11	Activities	20,122	153	6,195	26,470		26,470	(1,550)	24,920			11
12	Social Services	25,046	15		25,061		25,061		25,061			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Off. Ben. All.											15
16	TOTAL Health Care and Programs	1,106,585	159,015	548,747	1,814,347		1,814,347	(1,511)	1,812,836			16
	C. General Administration											
17	Administrative			180,000	180,000		180,000	(124,875)	55,125			17
18	Directors Fees											18
19	Professional Services			9,509	9,509		9,509	7,238	16,747			19
20	Dues, Fees, Subscriptions & Promotions			3,471	3,471		3,471	196	3,667			20
21	Clerical & General Office Expenses	43,754	6,285	5,441	55,480		55,480	41,443	96,923			21
22	Employee Benefits & Payroll Taxes			239,885	239,885		239,885		239,885			22
23	Inservice Training & Education							129	129			23
24	Travel and Seminar							38	38			24
25	Other Admin. Staff Transportation			5,735	5,735		5,735	6,835	12,570			25
26	Insurance-Prop.Liab.Malpractice			21,572	21,572		21,572	895	22,467			26
27	Other (specify):* Home Off. Ben. All.							14,627	14,627			27
28	TOTAL General Administration	43,754	6,285	465,613	515,652		515,652	(53,474)	462,178			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,382,785	334,033	1,118,760	2,835,578		2,835,578	(48,014)	2,787,564			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			152,754	152,754		152,754	(28,187)	124,567			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			122,982	122,982		122,982	36,140	159,122			32
33	Real Estate Taxes			32,566	32,566		32,566	318	32,884			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			40,452	40,452		40,452	566	41,018			35
36	Other (specify):*											36
37	TOTAL Ownership			348,754	348,754		348,754	8,837	357,591			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		227,785		227,785		227,785		227,785			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			35,588	35,588		35,588		35,588			42
43	Other (specify):* Non-allowable Costs	18,584	237	167,321	186,142		186,142	(186,142)				43
44	TOTAL Special Cost Centers	18,584	228,022	202,909	449,515		449,515	(186,142)	263,373			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,401,369	562,055	1,670,423	3,633,847		3,633,847	(225,319)	3,408,528			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	(954)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(47,047)	30		9
10	Interest and Other Investment Income	(979)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(74)	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	(166)	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	(133,825)	43		24
25	Fund Raising, Advertising and Promotional	(19,834)	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	(35,653)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (238,532)		\$	30

BHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the
general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	13,213	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 13,213		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (225,319)		37

*These costs are only allowable if they are necessary to meet minimum
licensing standards. Attach a schedule detailing the items included
on these lines.

C. Are the following expenses included in Sections A to D of pages 3
and 4? If so, they should be reclassified into Section E. Please
reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

STATE OF ILLINOIS

White Oak Rehabilitation & Health Care Center

Report Period Beginning:

Ending:

ID#

0047910

1/1/2011

12/31/2011

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Labs-Part A	\$ (17,294)	43	1
2	X-Rays-Part A	(13,861)	43	2
3	Offset Transportation Revenue	(1,550)	11	3
4	Offset Miscellaneous Office Supplies Revenue	(313)	21	4
5	Disallowed Special Events	(127)	43	5
6	Resident Flowers	(961)	43	6
7	Disallowed Chamber of Commerce Dues	(320)	20	7
8	Disallow Interest on Medicare Withholding	(1,227)	32	8
9				9
10				10
11				11
12				12
13				13
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38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(35,653)		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%	\$ 3,860	\$ 3,860	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%	252	252	5
6	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	1,574	1,574	6
7	V	7	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	880	880	7
8	V	10	Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	39	39	8
9	V	10A	Therapy		Petersen Health Care, Inc.	100.00%	0		9
10	V	15	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		10
11	V	17	Administrative	180,000	Petersen Health Care, Inc.	100.00%	55,125	(124,875)	11
12	V	19	Professional Services		Petersen Health Care, Inc.	100.00%	4,416	4,416	12
13	V								13
14	Total			\$ 180,000			\$ 66,189	\$ * (113,811)	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%	\$ 310	\$	310
16	V	21	Clerical and General Office		Petersen Health Care, Inc.	100.00%	35,986		35,986
17	V	23	Inservice Training & Education		Petersen Health Care, Inc.	100.00%	129		129
18	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	38		38
19	V	25	Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	3,307		3,307
20	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	895		895
21	V	27	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	14,627		14,627
22	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	5,171		5,171
23	V	32	Interest		Petersen Health Care, Inc.	100.00%	6,223		6,223
24	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	318		318
25	V	34	Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0		
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	564		564
27	V								
28	V								
29	V								
30	V								
31	V								
32	V								
33	V								
34	V								
35	V								
36	V								
37	V								
38	V								
39	Total			\$			\$ 67,568	\$ *	67,568

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

Facility Name & ID Number	White Oak Rehabilitation & Health Care Center	#	0047910	Report Period Beginning:	1/1/2011	Ending:	12/31/2011
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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 Care II, Inc.	100.00%	\$ 0	\$	15
16	V	2	Food		Petersen Health Care II, Inc.	100.00%	0		16
17	V	3	Housekeeping		Petersen Health Care II, Inc.	100.00%	0		17
18	V	4	Laundry		Petersen Health Care II, Inc.	100.00%	0		18
19	V	5	Utilities		Petersen Health Care II, Inc.	100.00%	0		19
20	V	6	Maintenance		Petersen Health Care II, Inc.	100.00%	1,316	1,316	20
21	V	7	Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	100.00%	0		21
22	V	10	Nursing and Medical Records		Petersen Health Care II, Inc.	100.00%	0		22
23	V	10A	Therapy		Petersen Health Care II, Inc.	100.00%	0		23
24	V	15	Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	100.00%	0		24
25	V	17	Administrative		Petersen Health Care II, Inc.	100.00%	0		25
26	V	19	Professional Services		Petersen Health Care II, Inc.	100.00%	2,822	2,822	26
27	V	20	Dues, Fees, Subs & Promotions		Petersen Health Care II, Inc.	100.00%	206	206	27
28	V	21	Clerical and General Office		Petersen Health Care II, Inc.	100.00%	5,770	5,770	28
29	V	23	Inservice Training & Education		Petersen Health Care II, Inc.	100.00%	0		29
30	V	24	Travel and Seminar		Petersen Health Care II, Inc.	100.00%	0		30
31	V	25	Other Admin. Staff Transport.		Petersen Health Care II, Inc.	100.00%	3,528	3,528	31
32	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care II, Inc.	100.00%	0		32
33	V	27	Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	100.00%	0		33
34	V	30	Depreciation		Petersen Health Care II, Inc.	100.00%	13,689	13,689	34
35	V	32	Interest		Petersen Health Care II, Inc.	100.00%	32,123	32,123	35
36	V	33	Real Estate Taxes		Petersen Health Care II, Inc.	100.00%	0		36
37	V	34	Rent-Facility and Grounds		Petersen Health Care II, Inc.	100.00%	0		37
38	V	35	Rent-Equipment & Vehicles		Petersen Health Care II, Inc.	100.00%	2	2	38
39	Total			\$			\$ 59,456	\$ * 59,456	39

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

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

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

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			<u>Toulon Health Care Center</u>	<u>Toulon</u>				1
2			<u>Tuscola Health Care Center</u>	<u>Tuscola</u>				2
3			<u>Twin Lakes Rehab & Health Care Center</u>	<u>Paris</u>				3
4			<u>Vandalia Rehab & Health Care Center</u>	<u>Vandalia</u>				4
5			<u>Watseka Health Care Center</u>	<u>Watseka</u>				5
6			<u>Westside Rehab & Care Center</u>	<u>West Frankfort</u>				6
7			<u>Whispering Oaks</u>	<u>Rosiclare</u>				7
8			<u>White Oak Rehab & Health Care Center</u>	<u>Mt. Vernon</u>				8
9			<u>Willow Rose Rehab & Health Care Center</u>	<u>Jerseyville</u>				9
10			<u>Sheldon Health Care Center</u>	<u>Sheldon</u>				10
11			<u>Tuscola Health Care Center</u>	<u>Tuscola</u>				11
12			<u>Effingham Health Care Center</u>	<u>Effingham</u>				12
13			<u>Collinsville Health Care Center</u>	<u>Collinsville</u>				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

Facility Name & ID Number White Oak Rehabilitation & Health Care Ce # 0047910 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number White Oak Rehabilitation & Health Care Center # 0047910 Report Period Beginning: 1/1/2011 Ending: 2/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	1,542,131	77	\$ 311,109	\$ 308,619	19,135	\$ 3,860	1
2	2	Food	Resident Days	1,542,131	77	1,436	0	19,135	18	2
3	3	Housekeeping	Resident Days	1,542,131	77	2,014	0	19,135	25	3
4	4	Laundry	Resident Days	1,542,131	77	0	0	19,135	0	4
5	5	Utilities	Resident Days	1,542,131	77	20,347	0	19,135	252	5
6	6	Maintenance	Resident Days	1,542,131	77	126,852	100,385	19,135	1,574	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,542,131	77	70,933	0	19,135	880	7
8	10	Nursing and Medical Records	Resident Days	1,542,131	77	3,130	0	19,135	39	8
9	10A	Therapy	Resident Days	1,542,131	77	0	0	19,135	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,542,131	77	0	0	19,135	0	10
11	17	Administrative	Resident Days	1,542,131	77	4,905,497	4,905,497	19,135	55,125	11
12	19	Professional Services	Resident Days	1,542,131	77	355,921	0	19,135	4,416	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,542,131	77	25,013	0	19,135	310	13
14	21	Clerical and General Office	Resident Days	1,542,131	77	2,900,214	2,467,442	19,135	35,986	14
15	23	Inservice Training & Education	Resident Days	1,542,131	77	10,374	0	19,135	129	15
16	24	Travel and Seminar	Resident Days	1,542,131	77	3,057	0	19,135	38	16
17	25	Other Admin. Staff Transport.	Resident Days	1,542,131	77	266,518	0	19,135	3,307	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,542,131	77	72,152	0	19,135	895	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,542,131	77	1,178,815	0	19,135	14,627	19
20	30	Depreciation	Resident Days	1,542,131	77	416,712	0	19,135	5,171	20
21	32	Interest	Resident Days	1,542,131	77	501,565	0	19,135	6,223	21
22	33	Real Estate Taxes	Resident Days	1,542,131	77	25,635	0	19,135	318	22
23	34	Rent-Facility and Grounds	Resident Days	1,542,131	77	0	0	19,135	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,542,131	77	45,440	0	19,135	564	24
25	TOTALS					\$ 11,242,734	\$ 7,781,943		\$ 133,757	25

Facility Name & ID Number White Oak Rehabilitation & Health Care Center# 0047910

Report Period Beginning:

1/1/2011Ending: 2/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Petersen Health Care II, Inc.

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309) 691-8113

Fax Number

(309) 691-8622

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	325,902	13	\$	\$	19,135	\$	1
2	2	Food	Resident Days	325,902	13			19,135		2
3	3	Housekeeping	Resident Days	325,902	13			19,135		3
4	4	Laundry	Resident Days	325,902	13			19,135		4
5	5	Utilities	Resident Days	325,902	13			19,135		5
6	6	Maintenance	Resident Days	325,902	13	22,420		19,135	1,316	6
7	7	Mgmt. Allocation of Benefits	Resident Days	325,902	13			19,135		7
8	10	Nursing and Medical Records	Resident Days	325,902	13			19,135		8
9	10A	Therapy	Resident Days	325,902	13			19,135		9
10	15	Mgmt. Allocation of Benefits	Resident Days	325,902	13			19,135		10
11	17	Administrative	Resident Days	325,902	13			19,135		11
12	19	Professional Services	Resident Days	325,902	13	48,058		19,135	2,822	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	325,902	13	3,502		19,135	206	13
14	21	Clerical and General Office	Resident Days	325,902	13	98,273		19,135	5,770	14
15	23	Inservice Training & Education	Resident Days	325,902	13			19,135		15
16	24	Travel and Seminar	Resident Days	325,902	13			19,135		16
17	25	Other Admin. Staff Transport.	Resident Days	325,902	13	60,087		19,135	3,528	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	325,902	13			19,135		18
19	27	Mgmt. Allocation of Benefits	Resident Days	325,902	13			19,135		19
20	30	Depreciation	Resident Days	325,902	13	233,155		19,135	13,689	20
21	32	Interest	Resident Days	325,902	13	547,113		19,135	32,123	21
22	33	Real Estate Taxes	Resident Days	325,902	13			19,135		22
23	34	Rent-Facility and Grounds	Resident Days	325,902	13			19,135		23
24	35	Rent-Equipment & Vehicles	Resident Days	325,902	13	36		19,135	2	24
25	TOTALS					\$ 1,012,644	\$		\$ 59,456	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	US Bank		X	Mortgage	Varies	05/06/06	\$ 1,800,000	\$ 1,522,797	12/8/11	0.0576	\$ 121,755	1
2												2
3								Interest Income Offset			(979)	3
4								Home Office Allocation-PHC			6,223	4
5								Home Office Allocation-PHC II			32,123	5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$ 1,800,000	\$ 1,522,797			\$ 159,122	9
	B. Non-Facility Related*											
10							Interest Paid on Medicare Withholding				1,227	10
11							Interest Offset on Medicare Withholding Interest Paid				(1,227)	11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 1,800,000	\$ 1,522,797			\$ 159,122	15

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2010 report.			\$	32,220	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	\$	31,906	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(314)	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	32,880	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.)			\$	318	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	32,884	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2006	27,362	8	
		2007	28,888	9	
		2008	30,322	10	
		2009	31,280	11	
		2010	31,906	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.

FACILITY NAME	<u>White Oak Rehabilitation & Health Care Center</u>	COUNTY	<u>Jefferson</u>
FACILITY IDPH LICENSE NUMBER	<u>0047910</u>		
CONTACT PERSON REGARDING THIS REPORT	<u>Mark Petersen</u>		
TELEPHONE	<u>(309)691-8113</u>	FAX #:	<u>(309) 691-8622</u>

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.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 18,008

B. General Construction Type: Exterior Brick Frame Block 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	125,030	2006	\$ 60,000	1
2					2
3	TOTALS	125,030		\$ 60,000	3

Facility Name & ID Number White Oak Rehabilitation & Health Care Center

0047910

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	65		2006	1965	\$ 2,015,000	\$	25	\$ 53,734	\$ 53,734	\$ 322,403
5										
6										
7										
8										
	Improvement Type**									
9	Land Improvements			2006	15,000		15	1,000	1,000	5,667
10	Sidewalks			2006	4,240		15	283	283	1,674
11	Plumbing			2006	5,360		20	268	268	1,474
12	Sign			2006	3,118		10	312	312	1,708
13	Water Heaters			2007	7,053		10	705	705	3,173
14	Fire/Sprinkler System			2007	48,100		15	3,206	3,206	14,427
15	Water Heater			2008	5,196		10	520	520	1,820
16										
17										
18										
19										
20										
21										
22										
23										
24										
25										
26										
27										
28	Land Improvements Booked					1,283			(1,283)	
29	Building Booked					80,600			(80,600)	
30	Building Improvement Booked					8,776			(8,776)	
31										
32										
33	2011-Home Office Allocation-Land Improvements				9,107			218	218	
34	2011-Home Office Allocation-Building Improvements				850			54	54	
35										
36										

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,113,024	\$ 90,659		\$ 60,300	\$ (30,359)	\$ 352,346	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	\$ 396,863	\$ 56,375	\$ 39,687	\$ (16,688)	10 yrs.	\$ 232,944	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Home Office Allocation			18,860	18,860			74
75	TOTALS	\$ 396,863	\$ 56,375	\$ 58,547	\$ 2,172		\$ 232,944	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	2007 Ford Cargo Van	2007	\$ 28,602	\$ 5,720	\$ 5,720		5	\$ 25,740	76
77										77
78										78
79										79
80	TOTALS			\$ 28,602	\$ 5,720	\$ 5,720			\$ 25,740	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)	\$ 2,598,489	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 152,754	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 124,567	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (28,187)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 611,030	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: \$41,018
- 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.

White Oak Rehabilitation & Health Care Center
0047910

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	\$	31,399
Dishwasher		708
Laundry Equipment		2,304
Copier		6,041
Home Office Allocation		<u>566</u>
		<u>41,018</u>

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

ALLOCATION OF COSTS (d)

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

		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

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

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

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

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

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

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

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

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

12345678											
	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(1), 10A(3)	27	hrs	\$ 1,471	12,940	\$ 194,097	\$	12,967	\$ 195,568	1
2	Licensed Speech and Language Development Therapist	10A(1), 10A(3)	354	hrs	18,066	7,401	111,013		7,755	129,079	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)		hrs		14,290	214,351	232	14,290	214,583	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				227,785		227,785	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify):										12
13	Other (specify): Respiratory Therapist	10A(3)				37	550		37	550	13
14	TOTAL				\$ 19,537	34,668	\$ 520,011	\$ 228,017	35,049	\$ 767,565	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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,027,992	\$ 2,027,992	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 165,000)	922,850	922,850	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	18,294	18,294	6
7	Other Prepaid Expenses	11,507	11,507	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,980,643	\$ 2,980,643	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		60,000	13
14	Buildings, at Historical Cost	2,094,240	2,024,107	14
15	Leasehold Improvements, at Historical Cost	177,349	88,917	15
16	Equipment, at Historical Cost	428,582	425,465	16
17	Accumulated Depreciation (book methods)	(833,916)	(611,030)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,866,255	\$ 1,987,459	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,846,898	\$ 4,968,102	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,587,944	\$ 1,587,944	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	82,646	82,646	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,393	6,393	31
32	Accrued Real Estate Taxes(Sch.IX-B)	32,880	32,880	32
33	Accrued Interest Payable	3,633	3,633	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	61,217	61,217	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,774,713	\$ 1,774,713	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,522,797	1,522,797	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)	\$ 1,522,797	\$ 1,522,797	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,297,510	\$ 3,297,510	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,549,388	\$ 1,670,592	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,846,898	\$ 4,968,102	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,180,674	1
2	Restatements (describe):		2
3	Rounding	(1)	3
4	2010 Allowance enter after CR completed	5,000	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,185,673	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	363,715	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)	\$ 363,715	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,549,388	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number White Oak Rehabilitation & Health Care Center # 0047910 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.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,963,441	1
2	Discounts and Allowances for all Levels	(379,962)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,583,479	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	931,618	6
7	Oxygen	5,097	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 936,715	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	954	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	392,225	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	45,495	20
21	Other Medical Services	35,852	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 474,526	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	979	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 979	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	313	28
28a	Transportation Revenue	1,550	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,863	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,997,562	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	505,579	31
32	Health Care	1,814,347	32
33	General Administration	515,652	33
	B. Capital Expense		
34	Ownership	348,754	34
	C. Ancillary Expense		
35	Special Cost Centers	413,927	35
36	Provider Participation Fee	35,588	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,633,847	40
41	Income before Income Taxes (line 30 minus line 40)**	363,715	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 363,715	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	1,387	1,387	\$ 42,448	\$ 30.60	1
2	Assistant Director of Nursing	1,578	1,605	36,987	23.04	2
3	Registered Nurses	7,283	7,363	156,692	21.28	3
4	Licensed Practical Nurses	14,465	14,932	258,336	17.30	4
5	CNAs & Orderlies	46,626	47,651	436,932	9.17	5
6	CNA Trainees					6
7	Licensed Therapist	287	381	19,537	51.28	7
8	Rehab/Therapy Aides	1,974	2,432	59,567	24.49	8
9	Activity Director	1,968	1,999	20,122	10.07	9
10	Activity Assistants					10
11	Social Service Workers	1,872	1,872	25,046	13.38	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	25,128	12.08	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,501	9,762	81,865	8.39	15
16	Dishwashers					16
17	Maintenance Workers	2,172	2,224	27,629	12.42	17
18	Housekeepers	7,844	8,321	70,837	8.51	18
19	Laundry	2,990	3,175	26,987	8.50	19
20	Administrator	2,080	2,080	55,125	26.50	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	3,551	3,567	43,754	12.27	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Sch 20A</u>	3,389	3,433	69,502	20.25	33
34	TOTAL (lines 1 - 33)	111,047	114,264	\$ 1,456,494 *	\$ 12.75	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	9,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,476	L10, C3	39
40	Physical Therapy Consultant	Monthly	3,658	L10a, C3	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)		\$ 16,134		49

C. CONTRACT NURSES

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

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

** See instructions.

White Oak Rehabilitation & Health Care Center

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

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	2,200	2,244	50,918	22.69
Marketing	1,189	1,189	18,584	15.63
TOTAL	3,389	3,433	69,502	

Facility Name & ID Number		White Oak Rehabilitation & Health Care Center		STATE OF ILLINOIS		# 0047910		Report Period Beginning:		1/1/2011		Page 21		Ending:		12/31/2011	
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							
Marsha McKinney		Administrator	0	43,333	Workers' Compensation Insurance		\$ 23,712	IDPH License Fee		\$							
Deborah Robertson		Administrator	0	11,792	Unemployment Compensation Insurance		83,507	Advertising: Employee Recruitment		965							
					FICA Taxes		109,423	Health Care Worker Background Check									
					Employee Health Insurance		22,935	(Indicate # of checks performed)									
					Employee Meals			Patient Background Checks		181							
					Illinois Municipal Retirement Fund (IMRF)*			Miscellaneous Licenses & Permits		370							
					Employee Relations		70	Miscellaneous Dues & Subscriptions		320							
					Employee Retirement		13	Home Office Allocation		516							
					Life Insurance		225										
TOTAL (agree to Schedule V, line 17, col. 1)																	
(List each licensed administrator separately.)				\$ 55,125													
B. Administrative - Other																	
Description				Amount													
Management Fees-See Page 6, Eliminated on P 3, C 7				\$ 180,000													
TOTAL (agree to Schedule V, line 17, col. 3)				\$ 180,000													
(Attach a copy of any management service agreement)																	
C. Professional Services																	
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		630													
Honkamp Kruger & Co.		Accounting Fees		778	N/A												
Brown & James		Legal Services		4,253					In-State Travel								
Charter Communications		Computer Services		363													
									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.)				\$ 9,509						line 24, col. 8)							
										\$ 38							
* Attach copy of IMRF notifications																	
**See instructions.																	

White Oak Rehabilitation & Health Care Center
0047910

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)		9,509
Home Office Allocation		
Heyl, Royster, Voelker & Allen	Legal	5
Henry County Recorder	Legal	-
Ginoli & Company	Accountants	613
Miscellaneous Vendors	Computer Services	50
Advanced Answers on Demand	Computer Services	2,562
Access 2 Go	Computer Services	252
Kemper Technology	Computer Services	117
MediFax	Computer Services	40
VisionShare/Ability Network	Computer Services	180
Advanced System Design	Computer Services	236
Simple LTC	Computer Services	296
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
Miscellaneous Vendors	Legal	2
Ginoli & Company	Accountants	1,014
U.S. Bank	Accountants	584
CDW	Computer Services	624
Polaris Group	Professional Fees	598
Total (agree to Schedule V, line 19, column 8)		<u><u>16,747</u></u>

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?
If YES, give association name and amount.

No
- (3) Did the nursing home make political contributions or payments to a political action organization?
If YES, have these costs been properly adjusted out of the cost report?

No

N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

No

N/A
- (5) Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

Yes

10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 6,650

Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports?
If NO, attach a complete explanation.

Yes
- (8) Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

No

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
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.
This amount is to be recorded on line 42 of Schedule V.

\$ 35,588
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

No
- (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?
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.

N/A
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.
Has any meal income been offset against related costs?

\$ 0

Yes

Indicate the amount. \$ 954
- (16) Travel and Transportation

a. Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

No

b. Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

Yes

1,538

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?
Indicate the amount of income earned from providing such transportation during this reporting period.

No

N/A
- (17) Has an audit been performed by an independent certified public accounting firm?
Firm Name:

Yes

Ginoli & Company
- (18) Have all costs which do not relate to the provision of long term care been adjusted out 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?
Attach invoices and a summary of services for all architect and appraisal fees.

N/A