

		FOR BHF USE					

LL1

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: <u>0046045</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Arcola Health Care Center</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2012</u> to <u>12/31/2012</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
Address: <u>422 E. Fourth St., P.O. Box 70</u> <u>Arcola</u> <u>61910</u>			
NumberCityZip Code			
County: <u>Douglas</u>			
Telephone Number: <u>(217) 268-3022</u> Fax # <u>(217) 268-4180</u>			
HFS ID Number: _____		Officer or Administrator of Provider Paid Preparer	
Date of Initial License for Current Owners: <u>11/09/93</u>			
Type of Ownership:			
☐ VOLUNTARY,NON-PROFIT ☐ Charitable Corp. ☐ Trust IRS Exemption Code _____ ☒ PROPRIETARY ☐ Individual ☐ Partnership ☐ Corporation ☒ "Sub-S" Corp. ☐ Limited Liability Co. ☐ Trust ☐ Other _____			

☐ GOVERNMENTAL☐ State☐ County☐ Other _____

Facility Name & ID Number Arcola Health Care Center# 0046045 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>50</u>	Skilled (SNF)	<u>50</u>	<u>18,250</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>50</u>	Intermediate (ICF)	<u>50</u>	<u>18,250</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>100</u>	TOTALS	<u>100</u>	<u>36,500</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			<u>595</u>	<u>595</u>	8
9	SNF/PED					9
10	ICF	<u>23,818</u>	<u>2,239</u>	<u>49</u>	<u>26,106</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>23,818</u>	<u>2,239</u>	<u>644</u>	<u>26,701</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 73.15%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?

YES

☒

NO

☐

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES

☐

NO

☒

I. On what date did you start providing long term care at this location?

Date started 11/9/1993

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

YES

☒Date 11/9/1993

NO

☐

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

YES

☒

NO

☐

If YES, enter number

of beds certified

50

and days of care provided

595Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL

☒

MODIFIED

CASH*

☐

CASH*

☐

Is your fiscal year identical to your tax year?

YES

☒NO ☐Tax Year: 12/31/12Fiscal Year: 12/31/12

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	A. General Services	1	2	3	4	5	6	7	8		
1	Dietary	173,139	19,829		192,968		192,968	4,861	197,829		1
2	Food Purchase		167,565		167,565		167,565	(6,558)	161,007		2
3	Housekeeping	124,943	21,753		146,696		146,696	37	146,733		3
4	Laundry	47,351	12,180		59,531		59,531	7	59,538		4
5	Heat and Other Utilities			56,965	56,965		56,965	384	57,349		5
6	Maintenance	31,635	14,403	23,807	69,845		69,845	2,696	72,541		6
7	Other (specify):* Home Off. Ben. All.							647	647		7
8	TOTAL General Services	377,068	235,730	80,772	693,570		693,570	2,074	695,644		8
	B. Health Care and Programs										
9	Medical Director			33,700	33,700		33,700		33,700		9
10	Nursing and Medical Records	906,487	69,117	20,497	996,101		996,101	(2,886)	993,215		10
10a	Therapy		46	47,523	47,569		47,569		47,569		10a
11	Activities	57,400	176	1,068	58,644		58,644	(13,883)	44,761		11
12	Social Services	67,379			67,379		67,379		67,379		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.										15
16	TOTAL Health Care and Programs	1,031,266	69,339	102,788	1,203,393		1,203,393	(16,769)	1,186,624		16
	C. General Administration										
17	Administrative			80,400	80,400		80,400	(10,900)	69,500		17
18	Directors Fees										18
19	Professional Services			4,680	4,680		4,680	26,257	30,937		19
20	Dues, Fees, Subscriptions & Promotions			3,022	3,022		3,022	(126)	2,896		20
21	Clerical & General Office Expenses	15,681	5,991	91,948	113,620		113,620	54,937	168,557		21
22	Employee Benefits & Payroll Taxes			194,797	194,797		194,797		194,797		22
23	Inservice Training & Education			35	35		35	92	127		23
24	Travel and Seminar							9	9		24
25	Other Admin. Staff Transportation			8,043	8,043		8,043	6,305	14,348		25
26	Insurance-Prop.Liab.Malpractice			32,900	32,900		32,900	1,039	33,939		26
27	Other (specify):* Home Off. Ben. All.							12,980	12,980		27
28	TOTAL General Administration	15,681	5,991	415,825	437,497		437,497	90,593	528,090		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,424,015	311,060	599,385	2,334,460		2,334,460	75,898	2,410,358		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			41,409	41,409		41,409	12,281	53,690			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			208,454	208,454		208,454	9,255	217,709			32
33	Real Estate Taxes			22,112	22,112		22,112	688	22,800			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			10,730	10,730		10,730	684	11,414			35
36	Other (specify):*											36
37	TOTAL Ownership			282,705	282,705		282,705	22,908	305,613			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		25,690		25,690		25,690		25,690			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			324,135	324,135		324,135		324,135			42
43	Other (specify):* Non-allowable Costs		1,445	26,062	27,507		27,507	(27,507)				43
44	TOTAL Special Cost Centers		27,135	350,197	377,332		377,332	(27,507)	349,825			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,424,015	338,195	1,232,287	2,994,497		2,994,497	71,299	3,065,796			45

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(6,722)	2		4
5	Telephone, TV & Radio in Resident Rooms	(9,782)	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	7,611	30		9
10	Interest and Other Investment Income	(30)	25		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(415)	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	(16,785)	43		18
19	Entertainment				19
20	Contributions	(50)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	22,947	43		24
25	Fund Raising, Advertising and Promotional	(2,697)	43		25
	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(38,125)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (44,048)		\$	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)	115,347	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 115,347		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 71,299		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

Arcola Health Care Center

ID# 0046045

Report Period Beginning: 1/1/2012

Ending: 12/31/2012

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	Labs-Part A	\$ (2,650)	43	1
2	X-Rays-Part A	(3,307)	43	2
3	Offset Vending Revenue	(11,347)	43	3
4	Offset Miscellaneous Office Supplies Revenue	(84)	21	4
5	Resident Flowers	(251)	43	5
6	Offset Transportaion Revenue	(13,883)	11	6
7	Disallowed Special Events	45	43	7
8	Offset Chamber of Commerce Dues	(500)	20	8
9	Interest IDES Offset	(3,215)	43	9
10	Offset Miscellaneous Nursing Supplies General	(2,933)	21	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	(38,125)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Arcola Health Care Center

0046045

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	4,861	0	0	0	0	0	0	0	0	0	4,861	1
2	Food Purchase	(6,722)	164	0	0	0	0	0	0	0	0	0	(6,558)	2
3	Housekeeping	0	37	0	0	0	0	0	0	0	0	0	37	3
4	Laundry	0	7	0	0	0	0	0	0	0	0	0	7	4
5	Heat and Other Utilities	0	384	0	0	0	0	0	0	0	0	0	384	5
6	Maintenance	0	2,696	0	0	0	0	0	0	0	0	0	2,696	6
7	Other (specify):*	0	647	0	0	0	0	0	0	0	0	0	647	7
8	TOTAL General Services	(6,722)	8,796	0	0	0	0	0	0	0	0	0	2,074	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	47	0	0	0	0	0	0	0	0	0	47	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(13,883)	0	0	0	0	0	0	0	0	0	0	(13,883)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(13,883)	47	0	0	0	0	0	0	0	0	0	(13,836)	16
	C. General Administration													
17	Administrative	0	(10,900)	0	0	0	0	0	0	0	0	0	(10,900)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	26,257	0	0	0	0	0	0	0	0	0	26,257	19
20	Fees, Subscriptions & Promotions	(500)	0	374	0	0	0	0	0	0	0	0	(126)	20
21	Clerical & General Office Expenses	(3,017)	0	55,021	0	0	0	0	0	0	0	0	52,004	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	92	0	0	0	0	0	0	0	0	92	23
24	Travel and Seminar	0	0	9	0	0	0	0	0	0	0	0	9	24
25	Other Admin. Staff Transportation	(30)	0	6,305	0	0	0	0	0	0	0	0	6,275	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,039	0	0	0	0	0	0	0	0	1,039	26
27	Other (specify):*	0	0	12,980	0	0	0	0	0	0	0	0	12,980	27
28	TOTAL General Administration	(3,547)	15,357	75,820	0	0	0	0	0	0	0	0	87,630	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(24,152)	24,200	75,820	0	0	0	0	0	0	0	0	75,868	29

Summary B

12/31/2012

[illegible]

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.

[illegible]

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

☒	X	YES	☐	NO
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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	<u>Dietary</u>	\$	<u>Petersen Health Care, Inc.</u>	100.00%	\$ 4,861	\$ 4,861	1
2	V	2	<u>Food</u>		<u>Petersen Health Care, Inc.</u>	100.00%	164	164	2
3	V	3	<u>Housekeeping</u>		<u>Petersen Health Care, Inc.</u>	100.00%	37	37	3
4	V	4	<u>Laundry</u>		<u>Petersen Health Care, Inc.</u>	100.00%	7	7	4
5	V	5	<u>Utilities</u>		<u>Petersen Health Care, Inc.</u>	100.00%	384	384	5
6	V	6	<u>Maintenance</u>		<u>Petersen Health Care, Inc.</u>	100.00%	2,696	2,696	6
7	V	7	<u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Care, Inc.</u>	100.00%	647	647	7
8	V	10	<u>Nursing and Medical Records</u>		<u>Petersen Health Care, Inc.</u>	100.00%	47	47	8
9	V	10A	<u>Therapy</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0		9
10	V	15	<u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0		10
11	V	17	<u>Administrative</u>	80,400	<u>Petersen Health Care, Inc.</u>	100.00%	69,500	(10,900)	11
12	V	19	<u>Professional Services</u>		<u>Petersen Health Care, Inc.</u>	100.00%	26,257	26,257	12
13	V								13
14	Total			\$ 80,400			\$ 104,600	\$ * 24,200	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%	\$ 374	\$	374
16	V	21	Clerical and General Office		Petersen Health Care, Inc.	100.00%	55,021		55,021
17	V	23	Inservice Training & Education		Petersen Health Care, Inc.	100.00%	92		92
18	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	9		9
19	V	25	Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	6,305		6,305
20	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	1,039		1,039
21	V	27	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	12,980		12,980
22	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	4,670		4,670
23	V	32	Interest		Petersen Health Care, Inc.	100.00%	9,285		9,285
24	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	688		688
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%	684		684
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			\$			\$ 91,147	\$ *	91,147

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

Facility Name & ID Number

Arcola Health Care Center

0046045

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Aledo Health Care Center	Aledo	Petersen Companies, I	Peoria	Mgmt/Bookkeeping	1
2			Arcola Health Care Center	Arcola	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	2
3			Aspen Rehab & Health Care	Silvis	Petersen Health Care,	Peoria	Mgmt/Bookkeeping	3
4			Batavia Rehab & Health Care Center	Batavia	Petersen Health Enter	Peoria	Mgmt/Bookkeeping	4
5			Bement Health Care Center	Bement	Petersen Health Opera	Peoria	Mgmt/Bookkeeping	5
6			Benton Rehab & Health Care Center	Benton	Petersen Health Syste	Peoria	Mgmt/Bookkeeping	6
7			Bloomington Rehab & Health Care Center	Bloomington	Petersen Hotels LLC	Peoria	Hospitality	7
8			Casey Health Care Center	Casey	Petersen Restaurants,	Peoria	Restaurant	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Health Care	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Care	Peoria	Mgmt/Bookkeeping	11
12			Countryview Terrace	Louisville	Petersen Health Care	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care	Peoria	Mgmt/Bookkeeping	13
14			Decatur Rehab & Health Care Center	Decatur	Petersen Health Care	Peoria	Lessor	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Osage Beach,	Osage Beach, MO	Lessor	15
16			Eastview Terrace	Sullivan	Petersen West Frankfo	West Frankfort	Lessor	16
17			El Paso Health Care Center	El Paso	Midwest Health Care,	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Poplar Bluff Health C	Poplar Bluff, MO	Lessor	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Roseville, LL	Roseville	Lessor	19
20			Flanagan Rehab & Health Care Center	Flanagan				20
21			Flora Gardens Care Center	Flora				21
22			Flora Health Care Center	Flora				22
23			Fondulac Rehab & Health Care Center	East Peoria				23
24			Havana Health Care Center	Havana				24
25			Illini Heritage Rehab & Health Care	Champaign				25
26			Jonesboro Rehab & Health Care Center	Jonesboro				26
27			Kewanee Care Home	Kewanee				27
28			LaHarpe Davier Health Care Center	LaHarpe				28
29			Lebanon Care Center	Lebanon				29
30			Marigold Rehab & Health Care Center	Galesburg				30

Facility Name & ID Number

Arcola Health Care Center

0046045

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Mason Point	Sullivan				1
2			McLeansboro Rehab & Health Care Center	McLeansboro				2
3			Mt. Vernon Health Care Center	Mt. Vernon				3
4			Newman Rehab & Health Care Center	Newman				4
5			Nokomis Rehab & Health Care Center	Nokomis				5
6			North Aurora Care Center	North Aurora				6
7			Orchard View Rehab & Health Care Center	Princeton				7
8			Palm Terrace of Mattoon	Mattoon				8
9			Piper City Rehab & Living Center	Piper City				9
10			Pleasant View Rehab & Health Care Center	Morrison				10
11			Polo Rehabilitation & Health Care Center	Polo				11
12			Prairie City Rehab & Health Care Center	Prairie City				12
13			Robings Manor Nursing Home	Brighton				13
14			Rochelle Gardens	Rochelle				14
15			Rochelle Rehab & Health Care Center	Rochelle				15
16			Rock Falls Rehab & Health Care Center	Rock Falls				16
17			Arrow Wood Independent Living	Rock Falls				17
18			Roseville Rehab and Health Care Center	Roseville				18
19			Rosiclare Rehab & Health Care Center	Rosiclare				19
20			Royal Oaks Care Center	Kewanee				20
21			Sandwich Rehab & Health Care Center	Sandwich				21
22			Iron Wood Independent Living	Sandwich				22
23			Shawnee Rose Care Center	Harrisburg				23
24			Shelbyville Rehab & Health Care Center	Shelbyville				24
25			South Elgin Rehab & Health Care Center	South Elgin				25
26			Sugar Creek Care Center	Watseka				26
27			Sullivan Health Care Center	Sullivan				27
28			Sunset Manor Nursing Home	Canton				28
29			Swansea Rehab & Health Care	Swansea				29
30			Timbercreek Rehab & Health Center	Pekin				30

Facility Name & ID Number

Arcola Health Care Center

0046045

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Toulon Health Care Center	Toulon				1
2			Tuscola Health Care Center	Tuscola				2
3			Twin Lakes Rehab & Health Care Center	Paris				3
4			Vandalia Rehab & Health Care Center	Vandalia				4
5			Watseka Health Care Center	Watseka				5
6			Westside Rehab & Care Center	West Frankfort				6
7			Whispering Oaks	Rosiclare				7
8			White Oak Rehab & Health Care Center	Mt. Vernon				8
9			Willow Rose Rehab & Health Care Center	Jerseyville				9
10			Sheldon Health Care Center	Sheldon				10
11			Tuscola Health Care Center	Tuscola				11
12			Effingham Health Care Center	Effingham				12
13			Collinsville Health Care Center	Collinsville				13
14			Ozark Rehab & Health Care Center	Osage Beach, MO				14
15			South Shore Health Care, LLC	Gary, IN				15
16			Cedargate Skilled Nursing Facility	Poplar Bluff, MO				16
17			Tarkio Rehab & Health Care Center	Tarkio, MO				17
18			Shangri-la Rehab & Living Center	Blue Springs, MO				18
19			Prairie Rose Care Center	Pana				19
20			Illini Heritage Rehab & Health Center	Champaign				20
21			Courtyard Estates of Kewanee	Kewanee				21
22			Courtyard Estates of Bradford	Bradford				22
23			Courtyard Estates of Galva	Galva				23
24			Courtyard Estates of Walcott	Walcott				24
25			Courtyard Village of Kewanee	Kewanee				25
26			Lakewood Village	Charleston				26
27			Courtyard Estates of Monmouth	Monmouth				27
28			Riverview Estates	Havana				28
29			Simple Blessings	Casey				29
30			Courtyard Estates of Bushnell	Bushnell				30

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Courtyard Estates of Canton	Canton				1
2			Legacy Estates of Monmouth	Monmouth				2
3			Courtyard Estates of Sullivan	Sullivan				3
4			Courtyard Estates of Peoria	Peoria				4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Arcola Health Care Center # 0046045 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Arcola Health Care Center# 0046045

Report Period Beginning:

1/1/2012Ending: 2/31/2012

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	1,569,393	74	\$ 285,707	\$ 284,214	26,701	\$ 4,861	1
2	2	Food	Resident Days	1,569,393	74	9,632	0	26,701	164	2
3	3	Housekeeping	Resident Days	1,569,393	74	2,201	0	26,701	37	3
4	4	Laundry	Resident Days	1,569,393	74	397	0	26,701	7	4
5	5	Utilities	Resident Days	1,569,393	74	22,546	0	26,701	384	5
6	6	Maintenance	Resident Days	1,569,393	74	158,485	73,431	26,701	2,696	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,569,393	74	38,057	0	26,701	647	7
8	10	Nursing and Medical Records	Resident Days	1,569,393	74	2,750	0	26,701	47	8
9	10A	Therapy	Resident Days	1,569,393	74	0	0	26,701	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,569,393	74	0	0	26,701	0	10
11	17	Administrative	Resident Days	1,569,393	74	4,353,655	4,353,655	26,701	69,500	11
12	19	Professional Services	Resident Days	1,569,393	74	1,543,275	0	26,701	26,257	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,569,393	74	21,988	0	26,701	374	13
14	21	Clerical and General Office	Resident Days	1,569,393	74	3,233,970	2,816,787	26,701	55,021	14
15	23	Inservice Training & Education	Resident Days	1,569,393	74	5,397	0	26,701	92	15
16	24	Travel and Seminar	Resident Days	1,569,393	74	535	0	26,701	9	16
17	25	Other Admin. Staff Transport.	Resident Days	1,569,393	74	370,568	0	26,701	6,305	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,569,393	74	61,077	0	26,701	1,039	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,569,393	74	762,912	0	26,701	12,980	19
20	30	Depreciation	Resident Days	1,569,393	74	274,514	0	26,701	4,670	20
21	32	Interest	Resident Days	1,569,393	74	545,764	0	26,701	9,285	21
22	33	Real Estate Taxes	Resident Days	1,569,393	74	40,424	0	26,701	688	22
23	34	Rent-Facility and Grounds	Resident Days	1,569,393	74	0	0	26,701	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,569,393	74	40,223	0	26,701	684	24
25	TOTALS					\$ 11,774,077	\$ 7,528,087		\$ 195,747	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	\$3,244 + int.	1/17/07	\$ 2,775,000	\$ 2,496,363	12/31/13	0.0832	\$ 208,454	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 2,775,000	\$ 2,496,363			\$ 208,454	9	
	B. Non-Facility Related*												
10												10	
11								Interest Income Offset			(30)	11	
12								Home Office Allocation-PHC			9,285	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ 9,255	14	
15	TOTALS (line 9+line14)						\$ 2,775,000	\$ 2,496,363			\$ 217,709	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

1. Real Estate Tax accrual used on 2011 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	22,920	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		2011		\$	22,184	2
3. Under or (over) accrual (line 2 minus line 1).				\$	(736)	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	22,848	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.					688	
TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	22,800	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

2007	24,661	8
2008	25,853	9
2009	22,410	10
2010	22,210	11
2011	22,184	12

Accrual based on prior year tax bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION \$		16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. **This denial must be no more than four years old at the time the cost report is filed.**

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	<u>Arcola Health Care Center</u>	COUNTY	<u>Douglas</u>
---------------	----------------------------------	--------	----------------

FACILITY IDPH LICENSE NUMBER 0046045

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

TELEPHONE (309)691-8113 FAX #: (309) 691-8622

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2011.

(A)		(B)	(C)	(D)
<u>Tax Index Number</u>		<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	01-14-09-200-00580	Long-Term Care Facility	\$ 21,887.12	\$ 21,887.12
2.	01-14-09-200-005	Long-Term Care Facility	\$ 297.24	\$ 297.24
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
TOTALS			\$ 22,184.36	\$ 22,184.36

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:	22,000	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	159,865	1993	\$ 44,078	1
2					2
3	TOTALS	159,865		\$ 44,078	3

Facility Name & ID Number Arcola Health Care Center

0046045

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

XI. OWNERSHIP COSTS (continued)

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

	1	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	100		1995	1975	\$ 859,153	\$	35	\$ 24,547	\$ 24,547	\$ 429,572	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvement		1993		13,499		20	675	675	13,162	9
10	Building Improvement		1994		31,000		20	1,550	1,550	28,625	10
11	Building Improvement		1995		10,602		20	530	530	8,990	11
12	Landscaping		1997		5,593		20	280	280	4,059	12
13	Parking Lot		1997		6,500		20	325	325	4,713	13
14	Carpeting		1997		934		20	47	47	680	14
15	Door Closer		1997		1,225		20	61	61	886	15
16	Driveway Grading		1998		784		15	52	52	703	16
17	Guttering		1998		1,273		15	85	85	1,147	17
18	Wiring		1998		6,426		20	321	321	4,335	18
19	Windows		1998		2,330		15	155	155	2,094	19
20	Siding		1998		12,606		20	630	630	8,506	20
21	Doors		1998		765		15	51	51	689	21
22	Sink		1998		901		20	45	45	810	22
23	Garage		1998		8,286		15	552	552	7,453	23
24	Wood Flooring		1999		1,174		20	59	59	736	24
25	Asphalt Lot		1999		4,680		20	234	234	2,925	25
26	Tile		1999		6,477		20	324	324	4,048	26
27	Vinyl Siding		1999		5,600		25	224	224	2,800	27
28	Door Alarms		2000		1,593		20	80	80	919	28
29	Water Heater		2000		5,075		20	254	254	2,921	29
30	Sidewalk		2000		876		20	44	44	506	30
31	Carpeting		2000		670		20	34	34	390	31
32	Scarf Swags/Valances		2001		6,043		20	302	302	3,020	32
33	Scarf Holders		2001		1,083		20	54	54	540	33
34	Fence		2001		2,000		20	100	100	1,000	34
35	Replacement Wall		2001		686		20	34	34	341	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Arcola Health Care Center

0046045

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

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

1 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	Security System	2002	\$ 5,959	\$	20	\$ 298	\$ 298	3,129	37
38	Sprinkler System	2002	4,946		20	247	247	2,596	38
39	Sign	2002	1,248		20	62	62	1,040	39
40	Medicare Wing Expansion	2003	100,808		20	5,040	5,040	47,881	40
41	Architect Fees	2003	1,343		20	67	67	670	41
42	Patio	2003	5,858		20	293	293	2,930	42
43	Medicare Wing Expansion	2003	2,500		20	125	125	1,188	43
44	Medicare Wing Expansion	2003	750		20	38	38	359	44
45	Medicare Wing Expansion	2003	1,500		20	75	75	713	45
46	Medicare Wing Expansion	2003	500		20	25	25	238	46
47	Furnace	2004	2,195		20	110	110	935	47
48	Roofing	2005	2,500		20	125	125	939	48
49	Asphalt West Lot	2006	21,480		20	1,074	1,074	6,981	49
50	Door Alarm	2007	2,117		10	212	212	1,166	50
51	Furnace/Air Conditioner	2007	3,985		10	399	399	2,194	51
52	Blinds	2007	4,431		10	443	443	2,437	52
53	Windows	2007	19,021		20	951	951	5,231	53
54	Water Heater	2008	6,500		7	928	928	4,176	54
55	Boiler	2008	3,425		20	172	172	774	55
56	6 New Sprinklers	2008	5,990		25	240	240	1,080	56
57	Fire Alarm Repair	2008	2,899		7	414	414	1,863	57
58	Kitchen Exhaust Fan	2010	8,000		10	800	800	2,000	58
59	Roof Replacement on North Building	2011	58,091		25	2,324		3,486	59
60									60
61									61
62	Land Improvements Booked			1,703			(1,703)		62
63	Building Booked			23,372			(23,372)		63
64	Building Improvement Booked			11,864			(11,864)		64
65									65
66	2012-Home Office Allocation-Land Improvements		1,166			75	75		66
67	2012-Home Office Allocation-Building Improvements		12,488			299	299		67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,277,534	\$ 36,939		\$ 46,485	\$ 7,222	\$ 630,576	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	\$ 27,777	\$ 4,157	\$ 2,777	\$ (1,380)	10 yrs.	\$ 14,034	71
72	Current Year Purchases	2,631	313	132	(181)	10 yrs.	132	72
73	Fully Depreciated Assets	230,329					230,329	73
74	Home Office Allocation			4,296	4,296			74
75	TOTALS	\$ 260,737	\$ 4,470	\$ 7,205	\$ 2,735		\$ 244,495	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	1994 Dodge Van	1998	\$ 28,010	\$	\$	\$		\$ 28,010	76
77	Facility	2005 Ford	2004	33,217					33,217	77
78										78
79										79
80	TOTALS			\$ 61,227	\$	\$	\$		\$ 61,227	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,643,576	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 41,409	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 53,690	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 12,281	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 936,298	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

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

15. Is Movable equipment rental included in building rental?

16. Rental Amount for movable equipment: \$ 6,570 Description: See Attached Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2012 Ford E250	\$ 822.05	\$ 4,844	17
18					18
19					19
20					20
21	TOTAL		\$ 822.05	\$ 4,844	21

10. Effective dates of current rental agreement:

Beginning

Ending

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

Fiscal Year Ending Annual Rent

12. /2013 \$

13. /2014 \$

14. /2015 \$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Arcola Health Care Center
0046045
Period Beginning 1/1/2012
Period End 12/31/2012

Schedule 14A

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

Medical Equipment	\$ 2,159
Dishwasher	727
Laundry Equipment	-
Copier	3,000
Home Office Allocation	684
	<u>6,570</u>

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM ☐

IN OTHER FACILITY ☐

COMMUNITY COLLEGE ☐

HOURS PER CNA _____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM ☐

IN OTHER FACILITY ☐

HOURS PER CNA _____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

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

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

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)										
		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	1,222	\$ 18,324	\$	1,222	\$ 18,324	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		268	4,026		268	4,026	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		1,678	25,173	46	1,678	25,219	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				25,690		25,690	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	3,168	\$ 47,523	\$ 25,736	3,168	\$ 73,259	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,872,083	\$ 1,872,083	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 10,000)	686,059	686,059	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	31,281	31,281	6
7	Other Prepaid Expenses	12,222	12,222	7
8	Accounts Receivable (owners or related parties)	2,608,147	2,608,147	8
9	Other(specify): Prepaid Lease	5,824	5,824	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,215,616	\$ 5,215,616	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		44,078	13
14	Buildings, at Historical Cost	941,489	871,641	14
15	Leasehold Improvements, at Historical Cost	314,147	405,893	15
16	Equipment, at Historical Cost	340,837	321,964	16
17	Accumulated Depreciation (book methods)	(852,016)	(936,298)	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): AR - Prior Owner	3,412	3,412	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 747,869	\$ 710,690	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,963,485	\$ 5,926,306	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 492,906	\$ 492,906	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	83,257	83,257	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,003	4,003	31
32	Accrued Real Estate Taxes(Sch.IX-B)	22,848	22,848	32
33	Accrued Interest Payable	6,978	6,978	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	52,747	52,747	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 662,739	\$ 662,739	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,496,363	2,496,363	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)	\$ 2,496,363	\$ 2,496,363	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,159,102	\$ 3,159,102	46
47	TOTAL EQUITY (page 18, line 24)	\$ 2,804,380	\$ 2,767,204	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,963,482	\$ 5,926,306	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,734,610	1
2	Restatements (describe):		2
3	Rounding	(3)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,734,607	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	69,773	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)	\$ 69,773	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)	\$ 2,804,380	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Arcola Health Care Center# 0046045Report Period Beginning: 1/1/2012Ending: 12/31/2012

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	1		2
	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,969,872	1
2	Discounts and Allowances for all Levels	(80,569)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,889,303	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	84,581	6
7	Oxygen	1,675	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 86,256	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	6,722	14
15	Telephone, Television and Radio	5,766	15
16	Rental of Facility Space		16
17	Sale of Drugs	43,106	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	5,639	20
21	Other Medical Services	820	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 62,053	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	30	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 30	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous & Transportation Revenue	16,900	28
28a	Vending Income	9,728	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 26,628	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,064,270	30

	1		2
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	693,570	31
32	Health Care	1,203,393	32
33	General Administration	437,497	33
	B. Capital Expense		
34	Ownership	282,705	34
	C. Ancillary Expense		
35	Special Cost Centers	53,197	35
36	Provider Participation Fee	324,135	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,994,497	40
41	Income before Income Taxes (line 30 minus line 40)**	69,773	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 69,773	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,496,547	44
45	Private Pay - Net Inpatient Revenue	280,125	45
46	Medicare - Net Inpatient Revenue	114,284	46
47	Other-(specify) <u>Charity Therapy Allowance</u>	(1,473)	47
48	Other-(specify) <u>Insurance Contractual Allowance</u>	(180)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,889,303	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,080	2,080	\$ 54,594	\$ 26.25	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,314	2,354	58,439	24.83	3
4	Licensed Practical Nurses	15,715	16,595	328,793	19.81	4
5	CNAs & Orderlies	37,228	38,091	394,027	10.34	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,385	3,520	33,328	9.47	10
11	Social Service Workers	4,504	4,504	67,379	14.96	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	31,851	15.31	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,366	15,963	141,288	8.85	15
16	Dishwashers					16
17	Maintenance Workers	2,000	2,064	31,635	15.33	17
18	Housekeepers	12,908	13,725	124,943	9.10	18
19	Laundry	4,997	5,340	47,351	8.87	19
20	Administrator	2,080	2,080	69,500	33.41	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,362	1,449	15,681	10.82	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: <u>Care Plan Coord.</u>	2,969	3,065	70,634	23.05	32
33	Other(specify) <u>Transportation</u>	1,910	2,060	24,072	11.69	33
34	TOTAL (lines 1 - 33)	110,898	114,970	\$ 1,493,515 *	\$ 12.99	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	33,700	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	5,254	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)		\$ 38,954		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	54	\$ 2,547	L10, C3	50
51	Licensed Practical Nurses	409	10,931	L10, C3	51
52	Certified Nurse Assistants/Aides	32	1,010	L10, C3	52
53	TOTAL (lines 50 - 52)	494	\$ 14,488		53

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

** See instructions.

XIX. SUPPORT SCHEDULES

[illegible]

*** Attach copy of IMRF notifications**

****See instructions.**

Arcola Health Care Center
0038919
Period Beginning 1/1/2012
Period End 12/31/2012

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		4,680
Home Office Allocation		
Sorling Northrup	Legal	83
Ginoli & Company	Accountants	882
Miscellaneous	Computer Services	73
Nebo Systems	Computer Services	2
Advanced Answers on Demand	Computer Services	4057
Access 2 Go	Computer Services	171
Stratus Networks	Computer Services	168
Kemper Technology	Computer Services	277
CCH	Computer Services	15
Medifax	Computer Services	32
Vision Share/Ability Network	Computer Services	309
Barracuda	Computer Services	11
CIAN	Computer Services	84
Comcast	Computer Services	26
Postini	Computer Services	262
Optimizer Systems	Other Prof Fees	41
Marotta Gund Budd & Dzera	Other Prof Fees	18787
David Budde	Other Prof Fees	16
Courtney Bourban	Other Prof Fees	231
All Scripts	Other Prof Fees	708
Heritage Enterprises	Other Prof Fees	17
Miscellaneous Vendors	Other Prof Fees	5
Total (agree to Schedule V, line 19, column 8)		<u>30,937</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													
4	N/A												
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 18,578 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. \$ 324,135
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 6,722
- (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. \$ 13,883
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? Adequate records have been maintained.
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli & Company
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? No
Attach invoices and a summary of services for all architect and appraisal fees.