

		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: 0047621

Facility Name: South Elgin Rehabilitation & Health Care Center

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

County: Kane

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

HFS ID Number:

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

Type of Ownership:

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

X PROPRIETARY
Individual
Partnership
Corporation
"Sub-S" Corp.
X Limited Liability Co.
Trust
Other

GOVERNMENTAL
State
County
Other

In the event there are further questions about this report, please contact:
Name: Mike Kocher Telephone Number: (309)689-5850
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2012 to 12/31/2012 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed)
(Type or Print Name) Mark B. Petersen
(Title) Chief Executive Officer

Paid Preparer

(Signed)
(Print Name and Title)
(Firm Name & Address)
(Telephone) () Fax # ()

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number South Elgin Rehabilitation & Health Care Center# 0047621 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>14</u>	Skilled (SNF)	<u>14</u>	<u>5,110</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>76</u>	Intermediate (ICF)	<u>76</u>	<u>27,740</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>90</u>	TOTALS	<u>90</u>	<u>32,850</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>2,386</u>	<u>2,386</u>	8
9	SNF/PED					9
10	ICF	<u>20,954</u>	<u>2,807</u>	<u>73</u>	<u>23,834</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>20,954</u>	<u>2,807</u>	<u>2,459</u>	<u>26,220</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 79.82%

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 10/1/05

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

YES

☒Date 10/1/2005

NO

☐

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

YES

☒

NO

☐

If YES, enter number

of beds certified

14

and days of care provided

2,386Medicare 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.

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total						
		1	2	3	4	5	6	7	8	9	10
	A. General Services										
1	Dietary	150,160	13,603	912	164,675		164,675	4,773	169,448		1
2	Food Purchase		152,629		152,629		152,629	56	152,685		2
3	Housekeeping	131,618	26,084		157,702		157,702	37	157,739		3
4	Laundry	17,337	8,678		26,015		26,015	7	26,022		4
5	Heat and Other Utilities			54,520	54,520		54,520	377	54,897		5
6	Maintenance	63,203	6,973	28,023	98,199		98,199	2,648	100,847		6
7	Other (specify):* Home Off. Ben. All.							636	636		7
8	TOTAL General Services	362,318	207,967	83,455	653,740		653,740	8,534	662,274		8
	B. Health Care and Programs										
9	Medical Director			12,100	12,100		12,100		12,100		9
10	Nursing and Medical Records	1,450,426	156,635	8,114	1,615,175		1,615,175	(61)	1,615,114		10
10a	Therapy			654,777	654,777		654,777		654,777		10a
11	Activities	36,299	33	471	36,803		36,803	(5,382)	31,421		11
12	Social Services	40,232			40,232		40,232		40,232		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.										15
16	TOTAL Health Care and Programs	1,526,957	156,668	675,462	2,359,087		2,359,087	(5,443)	2,353,644		16
	C. General Administration										
17	Administrative			373,000	373,000		373,000	(280,917)	92,083		17
18	Directors Fees										18
19	Professional Services			3,128	3,128		3,128	111,590	114,718		19
20	Dues, Fees, Subscriptions & Promotions			6,533	6,533		6,533	424	6,957		20
21	Clerical & General Office Expenses	37,187	5,255	33,369	75,811		75,811	54,945	130,756		21
22	Employee Benefits & Payroll Taxes			260,883	260,883		260,883		260,883		22
23	Inservice Training & Education			582	582		582	90	672		23
24	Travel and Seminar							9	9		24
25	Other Admin. Staff Transportation			5,222	5,222		5,222	6,246	11,468		25
26	Insurance-Prop.Liab.Malpractice			28,412	28,412		28,412	1,020	29,432		26
27	Other (specify):* Home Off. Ben. All.							12,746	12,746		27
28	TOTAL General Administration	37,187	5,255	711,129	753,571		753,571	(93,847)	659,724		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,926,462	369,890	1,470,046	3,766,398		3,766,398	(90,756)	3,675,642		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			23,154	23,154		23,154	3,485	26,639			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			58,266	58,266		58,266	72,957	131,223			32
33	Real Estate Taxes			34,947	34,947		34,947	675	35,622			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			15,983	15,983		15,983	745	16,728			35
36	Other (specify):*											36
37	TOTAL Ownership			132,350	132,350		132,350	77,862	210,212			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		105,358		105,358		105,358		105,358			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			284,829	284,829		284,829		284,829			42
43	Other (specify):* Non-allowable Costs	18,790	804	127,783	147,377		147,377	(147,377)				43
44	TOTAL Special Cost Centers	18,790	106,162	412,612	537,564		537,564	(147,377)	390,187			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,945,252	476,052	2,015,008	4,436,312		4,436,312	(160,271)	4,276,041			45

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

Facility Name & ID Number South Elgin Rehabilitation & Health Care Center # 0047621 Report Period Beginning: 1/1/2012 Ending: 12/31/2012
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.)

		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	(105)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,216)	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	(1,215)	30		9
10	Interest and Other Investment Income	(618)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(7)	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	(11,853)	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	(84,027)	43		24
25	Fund Raising, Advertising and Promotional	(21,054)	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	(32,250)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (155,345)		\$	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	2	
		Amount	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)	(4,926)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (4,926)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (160,271)		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	2	3	4	
		Yes	No	Amount	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
South Elgin Rehabilitation & Health Care Center

Page 5A

ID# 0047621
Report Period Beginning: 1/1/2012
Ending: 12/31/2012

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (26,647)	43	1
2	X-Rays-Part A	588	43	2
3	Offset Transportation Revenue	(5,382)	11	3
4	Offset Nursing Supplies Revenue	(107)	10	4
5	Offset Miscellaneous Office Supplies Revenue	(541)	21	5
6	Disallowed Special Events	(161)	43	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(32,250)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number South Elgin Rehabilitation & Health Care Center # 0047621 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	4,773	0	0	0	0	0	0	0	0	0	4,773	1
2	Food Purchase	(105)	161	0	0	0	0	0	0	0	0	0	56	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	377	0	0	0	0	0	0	0	0	0	377	5
6	Maintenance	0	2,648	0	0	0	0	0	0	0	0	0	2,648	6
7	Other (specify):*	0	636	0	0	0	0	0	0	0	0	0	636	7
8	TOTAL General Services	(105)	8,639	0	0	0	0	0	0	0	0	0	8,534	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	(107)	46	0	0	0	0	0	0	0	0	0	(61)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(5,382)	0	0	0	0	0	0	0	0	0	0	(5,382)	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	(5,489)	46	0	0	0	0	0	0	0	0	0	(5,443)	16
	C. General Administration													
17	Administrative	0	(280,917)	0	0	0	0	0	0	0	0	0	(280,917)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	25,784	0	85,806	0	0	0	0	0	0	0	111,590	19
20	Fees, Subscriptions & Promotions	0	0	367	57	0	0	0	0	0	0	0	424	20
21	Clerical & General Office Expenses	(541)	0	54,030	1,456	0	0	0	0	0	0	0	54,945	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	90	0	0	0	0	0	0	0	0	90	23
24	Travel and Seminar	0	0	9	0	0	0	0	0	0	0	0	9	24
25	Other Admin. Staff Transportation	0	0	6,191	55	0	0	0	0	0	0	0	6,246	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,020	0	0	0	0	0	0	0	0	1,020	26
27	Other (specify):*	0	0	12,746	0	0	0	0	0	0	0	0	12,746	27
28	TOTAL General Administration	(541)	(255,133)	74,453	87,374	0	0	0	0	0	0	0	(93,847)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(6,135)	(246,448)	74,453	87,374	0	0	0	0	0	0	0	(90,756)	29

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(1,215)	0	4,586	114	0	0	0	0	0	0	0	3,485	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(618)	0	9,118	64,457	0	0	0	0	0	0	0	72,957	32
33	Real Estate Taxes	0	0	675	0	0	0	0	0	0	0	0	675	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	672	73	0	0	0	0	0	0	0	745	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(1,833)	0	15,051	64,644	0	0	0	0	0	0	0	77,862	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(147,377)	0	0	0	0	0	0	0	0	0	0	(147,377)	43
44	TOTAL Special Cost Centers	(147,377)	0	0	0	0	0	0	0	0	0	0	(147,377)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(155,345)	(246,448)	89,504	152,018	0	0	0	0	0	0	0	(160,271)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark B. Petersen	100	See PG6 - Supp		See PG6 - Supp		

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

☒ YES ☐ NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 4,773	\$ 4,773	1
2	V	2	Food		Petersen Health Care, Inc.	100.00%	161	161	2
3	V	3	Housekeeping		Petersen Health Care, Inc.	100.00%	37	37	3
4	V	4	Laundry		Petersen Health Care, Inc.	100.00%	7	7	4
5	V	5	Utilities		Petersen Health Care, Inc.	100.00%	377	377	5
6	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	2,648	2,648	6
7	V	7	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	636	636	7
8	V	10	Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	46	46	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	373,000	Petersen Health Care, Inc.	100.00%	92,083	(280,917)	11
12	V	19	Professional Services		Petersen Health Care, Inc.	100.00%	25,784	25,784	12
13	V								13
14	Total			\$ 373,000			\$ 126,552	\$ * (246,448)	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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		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%	\$ 367	\$	367 15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	54,030		54,030 16
17	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	90		90 17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	9		9 18
19	V	25 Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	6,191		6,191 19
20	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	1,020		1,020 20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	12,746		12,746 21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	4,586		4,586 22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	9,118		9,118 23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	675		675 24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0		0 25
26	V	35 Rent-Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	672		672 26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 89,504	\$ *	89,504 39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 Dietary	\$	Petersen Health Operations, LLC	100.00%	\$ 0	\$ 15
16	V	2 Food		Petersen Health Operations, LLC	100.00%	0	16
17	V	3 Housekeeping		Petersen Health Operations, LLC	100.00%	0	17
18	V	4 Laundry		Petersen Health Operations, LLC	100.00%	0	18
19	V	5 Utilities		Petersen Health Operations, LLC	100.00%	0	19
20	V	6 Maintenance		Petersen Health Operations, LLC	100.00%	0	20
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	0	21
22	V	10 Nursing and Medical Records		Petersen Health Operations, LLC	100.00%	0	22
23	V	12 Social Services		Petersen Health Operations, LLC	100.00%	0	23
24	V	17 Administrative		Petersen Health Operations, LLC	100.00%	0	24
25	V	19 Professional Services		Petersen Health Operations, LLC	100.00%	85,806	85,806 25
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Operations, LLC	100.00%	57	57 26
27	V	21 Clerical and General Office		Petersen Health Operations, LLC	100.00%	1,456	1,456 27
28	V	22 Employee Benefits & Payroll		Petersen Health Operations, LLC	100.00%	0	28
29	V	23 Inservice Training & Education		Petersen Health Operations, LLC	100.00%	0	29
30	V	24 Travel and Seminar		Petersen Health Operations, LLC	100.00%	0	30
31	V	25 Other Admin. Staff Transport.		Petersen Health Operations, LLC	100.00%	55	55 31
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Operations, LLC	100.00%	0	32
33	V	27 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	0	33
34	V	30 Depreciation		Petersen Health Operations, LLC	100.00%	114	114 34
35	V	32 Interest		Petersen Health Operations, LLC	100.00%	64,457	64,457 35
36	V	33 Real Estate Taxes		Petersen Health Operations, LLC	100.00%	0	36
37	V	34 Rent-Facility and Grounds		Petersen Health Operations, LLC	100.00%	0	37
38	V	35 Rent-Equipment & Vehicles		Petersen Health Operations, LLC	100.00%	73	73 38
39	Total		\$			\$ 152,018	\$ * 152,018 39

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

Facility Name & ID Number South Elgin Rehabilitation & Health Care Center # 0047621 Report Period Beginning: 1/1/2012 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 South Elgin Rehabilitation & Health Care Center # 0047621 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 South Elgin Rehabilitation & Health Care Center # 0047621 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 South Elgin Rehabilitation & Health Care C # 0047621 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 South Elgin Rehabilitation & Health Care Center # 0047621 Report Period Beginning: 1/1/2012 Ending: 2/31/2012

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	1,569,393	74	\$ 285,707	\$ 284,214	26,220	\$ 4,773	1
2	2	Food	Resident Days	1,569,393	74	9,632	0	26,220	161	2
3	3	Housekeeping	Resident Days	1,569,393	74	2,201	0	26,220	37	3
4	4	Laundry	Resident Days	1,569,393	74	397	0	26,220	7	4
5	5	Utilities	Resident Days	1,569,393	74	22,546	0	26,220	377	5
6	6	Maintenance	Resident Days	1,569,393	74	158,485	73,431	26,220	2,648	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,569,393	74	38,057	0	26,220	636	7
8	10	Nursing and Medical Records	Resident Days	1,569,393	74	2,750	0	26,220	46	8
9	10A	Therapy	Resident Days	1,569,393	74	0	0	26,220	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,569,393	74	0	0	26,220	0	10
11	17	Administrative	Resident Days	1,569,393	74	4,353,655	4,353,655	26,220	92,083	11
12	19	Professional Services	Resident Days	1,569,393	74	1,543,275	0	26,220	25,784	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,569,393	74	21,988	0	26,220	367	13
14	21	Clerical and General Office	Resident Days	1,569,393	74	3,233,970	2,816,787	26,220	54,030	14
15	23	Inservice Training & Education	Resident Days	1,569,393	74	5,397	0	26,220	90	15
16	24	Travel and Seminar	Resident Days	1,569,393	74	535	0	26,220	9	16
17	25	Other Admin. Staff Transport.	Resident Days	1,569,393	74	370,568	0	26,220	6,191	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,569,393	74	61,077	0	26,220	1,020	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,569,393	74	762,912	0	26,220	12,746	19
20	30	Depreciation	Resident Days	1,569,393	74	274,514	0	26,220	4,586	20
21	32	Interest	Resident Days	1,569,393	74	545,764	0	26,220	9,118	21
22	33	Real Estate Taxes	Resident Days	1,569,393	74	40,424	0	26,220	675	22
23	34	Rent-Facility and Grounds	Resident Days	1,569,393	74	0	0	26,220	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,569,393	74	40,223	0	26,220	672	24
25	TOTALS					\$ 11,774,077	\$ 7,528,087		\$ 216,056	25

Facility Name & ID Number South Elgin Rehabilitation & Health Care Center # 0047621 Report Period Beginning: 1/1/2012 Ending: 2/31/2012

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	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	404,785	21	\$	\$	26,220	\$	1
2	2	Food	Resident Days	404,785	21			26,220		2
3	3	Housekeeping	Resident Days	404,785	21			26,220		3
4	4	Laundry	Resident Days	404,785	21			26,220		4
5	5	Utilities	Resident Days	404,785	21			26,220		5
6	6	Maintenance	Resident Days	404,785	21			26,220		6
7	7	Mgmt. Allocation of Benefits	Resident Days	404,785	21			26,220		7
8	10	Nursing and Medical Records	Resident Days	404,785	21			26,220		8
9	12	Social Services	Resident Days	404,785	21			26,220		9
10	17	Administrative	Resident Days	404,785	21			26,220		10
11	19	Professional Services	Resident Days	404,785	21	1,324,676		26,220	85,806	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	404,785	21	876		26,220	57	12
13	21	Clerical and General Office	Resident Days	404,785	21	22,478		26,220	1,456	13
14	22	Employee Benefits & Payroll	Resident Days	404,785	21			26,220		14
15	23	Inservice Training & Education	Resident Days	404,785	21			26,220		15
16	24	Travel and Seminar	Resident Days	404,785	21			26,220		16
17	25	Other Admin. Staff Transport.	Resident Days	404,785	21	849		26,220	55	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	404,785	21			26,220		18
19	27	Mgmt. Allocation of Benefits	Resident Days	404,785	21			26,220		19
20	30	Depreciation	Resident Days	404,785	21	1,761		26,220	114	20
21	32	Interest	Resident Days	404,785	21	995,096		26,220	64,457	21
22	33	Real Estate Taxes	Resident Days	404,785	21			26,220		22
23	34	Rent-Facility and Grounds	Resident Days	404,785	21			26,220		23
24	35	Rent-Equipment & Vehicles	Resident Days	404,785	21	1,130		26,220	73	24
25	TOTALS					\$ 2,346,866	\$		\$ 152,018	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	Bank of America		X	Mortgage	Varies	1/19/07	\$ 750,000	\$ 701,544	12/31/13	Varies	\$ 58,266	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 750,000	\$ 701,544			\$ 58,266	9	
	B. Non-Facility Related*												
10												10	
11								Interest Income Offset			(618)	11	
12								Home Office Allocation-PHC			9,118	12	
13								Home Office Allocation-PHO			64,457	13	
14	TOTAL Non-Facility Related						\$	\$			\$ 72,957	14	
15	TOTALS (line 9+line14)						\$ 750,000	\$ 701,544			\$ 131,223	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.)

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2011 report.			\$	38,700	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		2011	\$	36,279	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(2,421)	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	37,368	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.)			\$	675	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	35,622	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2007	56,174	8	
		2008	56,782	9	
		2009	35,225	10	
		2010	37,519	11	
		2011	36,279	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 South Elgin Rehabilitation & Health Care Center COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0047621

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 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.	<u>06-34-226-014</u>	<u>Long-Term Care Facility</u>	\$ <u>36,279.12</u>	\$ <u>36,279.12</u>
2.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
3.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
TOTALS			\$ <u><u>36,279.12</u></u>	\$ <u><u>36,279.12</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

Attach a copy of the original 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.**

- A. Square Feet: 15,169
- B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1
- C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)
- D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)
- E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	131,116	2005	\$ 467,500	1
2					2
3	TOTALS	131,116		\$ 467,500	3

XI. OWNERSHIP COSTS (continued)

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

	1	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			2005	1970	\$ ***	\$		\$		\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Wheelchair			2006	15,515		25	621	621	4,036	9
10	Backflow Prevention			2006	14,325		25	573	573	3,725	10
11	Walls			2006	3,550		25	142	142	923	11
12	7 Rooms-Floor Replacement, Painting, Wallpaper, Trim Labor			2007	10,400		20	520	520	2,860	12
13	7 Rooms-Floor Tile, Sink, Supplies, Paint, Wallpaper			2007	5,100		20	255	255	1,403	13
14	Fire Sprinkler System Repair			2008	2,580		15	172	172	774	14
15	Dry Pipe Valve Accelerator Replacement			2008	8,436		15	562	562	2,529	15
16	Sprinkler System Repairs			2008	5,156		15	344	344	1,548	16
17	Water Line Repairs			2008	6,969		15	464	464	2,088	17
18	Sprinkler System Replacement			2009	27,836		20	1,392	1,392	4,872	18
19	Pendant Sprinkler System			2010	5,462		7	780	780	1,950	19
20	Water Heater			2011	5,120		7	732	732	1,098	20
21	Air Conditioner			2012	3,046		15	102	102	102	21
22	Water Heater			2012	11,870		7	848	848	848	22
23											23
24											24
25											25
26											26
27											27
28	*** Note:										28
29	Facility was purchased as part of a multi-facility										29
30	sale. For purposes of allocating the purchase										30
31	price, appraisers valued the building and land										31
32	at the value of the bare land only. The allocated										32
33	amount appears on page 11 (Sch XI (A) line 1, column 4).										33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62	Building Improvement Booked		6,119			(6,119)		62
63								63
64	2012-Home Office Allocation-Land Improvements	1,145			73	73		64
65	2012-Home Office Allocation-Building Improvements	12,263			294	294		65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 138,773	\$ 6,119		\$ 7,874	\$ 1,755	\$ 28,756	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	\$176,400	\$17,035	\$14,432	\$(2,603)	5-10 yrs.	\$145,283	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Home Office Allocation			4,333	4,333			74
75	TOTALS	\$176,400	\$17,035	\$18,765	\$1,730		\$145,283	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 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)	\$782,673	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$23,154	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$26,639	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$3,485	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$174,039	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES
- ☐ NO

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

**

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-
-

9. Option to Buy:
- ☐ YES
- ☐ NO
- Terms:
-
- *

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

15. Is Movable equipment rental included in building rental?
- ☐ YES
- ☐ NO
16. Rental Amount for movable equipment: \$ 9,790
- Description: See Attached Schedule 14A
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2006 Ford E250	\$ 578.17	\$ 6,938	17
18					18
19					19
20					20
21	TOTAL		\$ 578.17	\$ 6,938	21

10. Effective dates of current rental agreement:

Beginning

Ending

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

	Fiscal Year Ending	Annual Rent
12.	/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.

South Elgin Rehabilitation & Health Care Center
0047621

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	\$	2,166
Dishwasher		732
Laundry Equipment		-
Copier		6,147
Home Office Allocation		745
		<u>9,790</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

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

		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)	\$			

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	\$	17,558	\$ 263,370	\$	17,558	\$ 263,370	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2,317	34,752		2,317	34,752	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		23,770	356,545		23,770	356,545	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				105,358		105,358	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Respiratory Therapy	10A(3)			7	110		7	110	13
14	TOTAL			\$	43,652	\$ 654,777	\$ 105,358	43,652	\$ 760,135	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	\$ 3,277,048	\$ 3,277,048	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 260,000)	1,697,465	1,697,465	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	28,261	28,261	6
7	Other Prepaid Expenses	12,521	12,521	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Other Prepaid Expenses	5,109	5,109	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,020,404	\$ 5,020,404	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		467,500	13
14	Buildings, at Historical Cost	467,500	12,263	14
15	Leasehold Improvements, at Historical Cost	113,240	126,510	15
16	Equipment, at Historical Cost	176,400	176,400	16
17	Accumulated Depreciation (book methods)	(189,239)	(174,039)	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)	\$ 567,901	\$ 608,634	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,588,305	\$ 5,629,038	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,247,952	\$ 1,247,952	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	39,812	39,812	30
31	Accrued Taxes Payable (excluding real estate taxes)	25,259	25,259	31
32	Accrued Real Estate Taxes(Sch.IX-B)	37,368	37,368	32
33	Accrued Interest Payable	1,936	1,936	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	29,779	29,779	36
37	Accrued Management Fee	204,559	204,559	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,586,665	\$ 1,586,665	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	701,544	701,544	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)	\$ 701,544	\$ 701,544	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,288,209	\$ 2,288,209	46
47	TOTAL EQUITY (page 18, line 24)	\$ 3,300,096	\$ 3,340,829	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,588,305	\$ 5,629,038	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,561,252	1
2	Restatements (describe):		2
3	Rounding		3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,561,252	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	738,844	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)	\$ 738,844	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)	\$ 3,300,096	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number South Elgin Rehabilitation & Health Care Center # 0047621 Report Period Beginning: 1/1/2012Ending: 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	\$ 4,231,634	1
2	Discounts and Allowances for all Levels	(303,075)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,928,559	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,001,734	6
7	Oxygen	1,820	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,003,554	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	105	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	214,114	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	16,177	20
21	Other Medical Services	5,999	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 236,395	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	618	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 618	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	648	28
28a	Transportation Revenue	5,382	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 6,030	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,175,156	30

	1		2
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	653,740	31
32	Health Care	2,359,087	32
33	General Administration	753,571	33
	B. Capital Expense		
34	Ownership	132,350	34
	C. Ancillary Expense		
35	Special Cost Centers	252,735	35
36	Provider Participation Fee	284,829	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,436,312	40
41	Income before Income Taxes (line 30 minus line 40)**	738,844	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 738,844	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 3,081,401	44
45	Private Pay - Net Inpatient Revenue	413,733	45
46	Medicare - Net Inpatient Revenue	474,665	46
47	Other-(specify) <u>Charity Therapy Allowance</u>	(38,383)	47
48	Other-(specify) <u>Insurance Contractual Allowance</u>	(2,857)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,928,559	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.

		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	1,907	1,907	\$ 75,977	\$ 39.84	1
2	Assistant Director of Nursing	1,671	1,671	49,966	29.90	2
3	Registered Nurses	16,514	17,190	548,759	31.92	3
4	Licensed Practical Nurses	6,978	7,141	188,414	26.38	4
5	CNAs & Orderlies	44,275	45,165	496,673	11.00	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,965	2,027	27,020	13.33	9
10	Activity Assistants	1,122	1,122	9,279	8.27	10
11	Social Service Workers	2,080	2,080	40,232	19.34	11
12	Dietician					12
13	Food Service Supervisor	2,326	2,326	31,548	13.56	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,026	11,960	118,612	9.92	15
16	Dishwashers					16
17	Maintenance Workers	4,088	4,152	63,203	15.22	17
18	Housekeepers	14,598	15,176	131,618	8.67	18
19	Laundry	1,908	2,036	17,337	8.52	19
20	Administrator	2,080	2,080	92,083	44.27	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,538	2,538	37,187	14.65	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	506	506	7,902	15.62	31
32	Other Health Care Care Plan Coord	2,225	2,353	82,735	35.16	32
33	Other(specify) Marketing	1,378	1,378	18,790	13.64	33
34	TOTAL (lines 1 - 33)	119,185	122,808	\$ 2,037,335 *	\$ 16.59	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	18	\$ 912	L1, C3	35
36	Medical Director	Monthly	12,100	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	5,966	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	18	\$ 18,978		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	189	\$ 7,918	L10, C3	50
51	Licensed Practical Nurses	50	1,704	L10, C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	239	\$ 9,622		53

Template

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	-	-		#DIV/0!
Restorative Aide				#DIV/0!
Certified Medical Technician				#DIV/0!
Alzheimer's Coordinator				#DIV/0!
Restorative Nurse				#DIV/0!
Transportation	-	-	-	#DIV/0!
Marketing				#DIV/0!
TOTAL				

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description	Amount	
Elizabeth Gilbert	Administrator	0	\$ 20,833	Workers' Compensation Insurance		\$ 46,180	IDPH License Fee	\$ 3,980	
Mary Gilliam	Administrator	0	71,250	Unemployment Compensation Insurance		44,782	Advertising: Employee Recruitment		
				FICA Taxes		150,320	Health Care Worker Background Check		
				Employee Health Insurance		16,754	(Indicate # of checks performed)		
				Employee Meals			Patient Background Checks	157 1,570	
				Illinois Municipal Retirement Fund (IMRF)*			Miscellaneous Licenses & Permits	983	
				Employee Relations		1,420	Home Office Allocation	424	
				Employee Retirement		1,427			
TOTAL (agree to Schedule V, line 17, col. 1)									
(List each licensed administrator separately.)			\$ 92,083						
B. Administrative - Other									
Description			Amount						
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 373,000						
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 373,000	TOTAL (agree to Schedule V, line 22, col.8)		\$ 260,883	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 6,957
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
C. Professional Services				Description	Line #	Amount	Description	Amount	
Vendor/Payee	Type		Amount						
E-Health Data Solutions	Computer Services		\$ 1,460			\$	Out-of-State Travel	\$	
Comcast Cable	Computer Services		643						
Nigro, Westfall, Gryska	Reversal of 2011 Invoice		(3)	N/A			In-State Travel		
Honkamp Kruger & Co.	Accounting Fees		1,028						
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	Seminar Expense		
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 3,128				Home Office Allocation		9
							Entertainment Expense		()
							(agree to Sch. V, line 24, col. 8)		
							TOTAL		\$ 9

*** Attach copy of IMRF notifications**

****See instructions.**

South Elgin Rehabilitation & Health Care Center
0047621

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)		3,128
Home Office Allocation		
Sorling Northrup	Legal	82
Ginoli & Company	Accountants	2,934
Miscellaneous	Computer Services	69
Nebo Systems	Computer Services	2
Advanced Answers on Demand	Computer Services	3984
Access 2 Go	Computer Services	168
Stratus Networks	Computer Services	165
Kemper Technology	Computer Services	272
CCH	Computer Services	14
Medifax	Computer Services	32
Vision Share/Ability Network	Computer Services	304
Barracuda	Computer Services	11
CIAN	Computer Services	83
Comcast	Computer Services	26
Postini	Computer Services	258
Optimizer Systems	Other Prof Fees	41
Marotta Gund Budd & Dzera	Other Prof Fees	102187
David Budde	Other Prof Fees	15
Courtney Bourban	Other Prof Fees	227
All Scripts	Other Prof Fees	696
Heritage Enterprises	Other Prof Fees	16
Miscellaneous Vendors	Other Prof Fees	4
Total (agree to Schedule V, line 19, column 8)		<u>114,718</u>

Period Beginning1/1/2011Period End12/31/2011

Schedule 21B

XIX. SUPPORT SCHEDULE
Legal Fees

Facility			
Vendor/Payee	Invoice Total	Allocation %	Total
		100%	-
Home Office Allocation			
Heyl, Royster, Voelker, and Allen			-
GoffWilson			-
Jackson Lewis			-
Peter Gartelos			-
Miscellaneous Vendors			-
Total Legal Fees			-

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. \$ 35,126 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. \$ 284,829
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. \$ 105
- (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. \$ 5,382
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.