		FOR BHF USE					

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

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

I. IDPH License ID Number: 0050823

Facility Name: Prairie City Health Care Center

Address: 825 E Main St RR #2-Box 97 (Number) Prairie City (City) 61470 (Zip Code)

County: McDonough

Telephone Number: (309)775-3313 **Fax #** (309)775-3311

HFS ID Number:

Date of Initial License for Current Owners: 9/9/2008

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Larry Templin **Telephone Number:** (309) 689-5869
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2011 to 12/31/2011 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

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

Paid Preparer

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

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

Facility Name & ID Number Prairie City Health Care Center # 0050823 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	47	Skilled (SNF)	47	17,155	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	47	TOTALS	47	17,155	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	5,981	1,828	658	8,467	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,981	1,828	658	8,467	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 49.36%

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

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

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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 9/9/2008

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 9/9/2008 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 47 and days of care provided 658

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

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

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

Facility Name & ID Number Prairie City Health Care Center # 0050823 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	88,441	6,717		95,158		95,158	1,708	96,866			1
2	Food Purchase		60,261		60,261		60,261	(8,717)	51,544			2
3	Housekeeping	62,815	8,852		71,667		71,667	11	71,678			3
4	Laundry		7,532		7,532		7,532		7,532			4
5	Heat and Other Utilities			31,517	31,517		31,517	112	31,629			5
6	Maintenance	19,664	6,168	10,517	36,349		36,349	696	37,045			6
7	Other (specify):* Home Off. Ben. All.							389	389			7
8	**TOTAL General Services**	170,920	89,530	42,034	302,484		302,484	(5,801)	296,683			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	323,468	30,707	1,842	356,017		356,017	17	356,034			10
10a	Therapy			62,264	62,264		62,264		62,264			10a
11	Activities	17,802	559	14	18,375		18,375	(743)	17,632			11
12	Social Services	7,689			7,689		7,689		7,689			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Off. Ben. All.											15
16	**TOTAL Health Care and Programs**	348,959	31,266	70,120	450,345		450,345	(726)	449,619			16
	C. General Administration											
17	Administrative			68,400	68,400		68,400	(7,753)	60,647			17
18	Directors Fees											18
19	Professional Services			4,900	4,900		4,900	2,622	7,522			19
20	Dues, Fees, Subscriptions & Promotions			5,542	5,542		5,542	137	5,679			20
21	Clerical & General Office Expenses		2,083	4,748	6,831		6,831	17,177	24,008			21
22	Employee Benefits & Payroll Taxes			85,203	85,203		85,203		85,203			22
23	Inservice Training & Education			600	600		600	57	657			23
24	Travel and Seminar							17	17			24
25	Other Admin. Staff Transportation			4,996	4,996		4,996	1,463	6,459			25
26	Insurance-Prop.Liab.Malpractice			16,226	16,226		16,226	396	16,622			26
27	Other (specify):* Home Off. Ben. All.							6,472	6,472			27
28	**TOTAL General Administration**		2,083	190,615	192,698		192,698	20,588	213,286			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	519,879	122,879	302,769	945,527		945,527	14,061	959,588			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.

Facility Name & ID Number Prairie City Health Care Center #0050823 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			41,649	41,649		41,649	(4,138)	37,511			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			35,330	35,330		35,330	(9,954)	25,376			32
33	Real Estate Taxes			4,916	4,916		4,916	141	5,057			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			2,619	2,619		2,619	249	2,868			35
36	Other (specify):*											36
37	**TOTAL Ownership**			84,514	84,514		84,514	(13,702)	70,812			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		32,150		32,150		32,150		32,150			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			25,733	25,733		25,733		25,733			42
43	Other (specify):* Non-allowable Costs		389	6,444	6,833		6,833	(6,833)				43
44	**TOTAL Special Cost Centers**		32,539	32,177	64,716		64,716	(6,833)	57,883			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	519,879	155,418	419,460	1,094,757		1,094,757	(6,474)	1,088,283			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 Prairie City Health Care Center # 0050823 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(8,725)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,742)	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	(6,426)	30		9
10	Interest and Other Investment Income	(922)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(169)	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	10,463	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	(6,392)	43		24
25	Fund Raising, Advertising and Promotional	(3,733)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(13,809)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (35,455)		$	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)	28,981	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 28,981		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (6,474)		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

Prairie City Health Care Center

ID# 0050823

Report Period Beginning: 1/1/2011

Ending: 12/31/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs-Part A	$ (1,245)	43	1
2	X-Rays-Part A	(129)	43	2
3	Disallowed Special Events	114	43	3
4	Disallow related party interest expense	(11,786)	32	4
5	Offset Miscellaneous Office Supplies Revenue	(20)	21	5
6	Offset Transportation Revenue	(743)	11	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
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40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(13,809)		49

Facility Name & ID Number Prairie City Health Care Center # 0050823 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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. [X] YES [ ] NO

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

1 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%	$ 1,708	$ 1,708	1
2	V	2	Food		Petersen Health Care, Inc.	100.00%	8	8	2
3	V	3	Housekeeping		Petersen Health Care, Inc.	100.00%	11	11	3
4	V	4	Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5	Utilities		Petersen Health Care, Inc.	100.00%	112	112	5
6	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	696	696	6
7	V	7	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	389	389	7
8	V	10	Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	17	17	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	68,400	Petersen Health Care, Inc.	100.00%	60,647	(7,753)	11
12	V	19	Professional Services		Petersen Health Care, Inc.	100.00%	1,954	1,954	12
13	V								13
14	Total			$ 68,400			$ 65,542	$ * (2,858)	14

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

Facility Name & ID Number Prairie City Health Care Center # 0050823 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

VII. RELATED PARTIES (continued)

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

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

1 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)	
15	V	20	Dues, Fees, Subs & Promotions	$	Petersen Health Care, Inc.	100.00%	$ 137	$ 137	15
16	V	21	Clerical and General Office		Petersen Health Care, Inc.	100.00%	15,924	15,924	16
17	V	23	Inservice Training & Education		Petersen Health Care, Inc.	100.00%	57	57	17
18	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	17	17	18
19	V	25	Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	1,463	1,463	19
20	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	396	396	20
21	V	27	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	6,472	6,472	21
22	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	2,288	2,288	22
23	V	32	Interest		Petersen Health Care, Inc.	100.00%	2,754	2,754	23
24	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	141	141	24
25	V	34	Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0		25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	249	249	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			$			$ 29,898	$ * 29,898	39

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

Facility Name & ID Number Prairie City Health Care Center # 0050823 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

VII. RELATED PARTIES (continued)

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

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

1 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)	
15	V	1	Dietary	$	Midwest Health Operations, LLC	100.00%	$ 0	$	15
16	V	2	Food		Midwest Health Operations, LLC	100.00%	0		16
17	V	3	Housekeeping		Midwest Health Operations, LLC	100.00%	0		17
18	V	4	Laundry		Midwest Health Operations, LLC	100.00%	0		18
19	V	5	Utilities		Midwest Health Operations, LLC	100.00%	0		19
20	V	6	Maintenance		Midwest Health Operations, LLC	100.00%	0		20
21	V	7	Mgmt. Allocation of Benefits		Midwest Health Operations, LLC	100.00%	0		21
22	V	10	Nursing and Medical Records		Midwest Health Operations, LLC	100.00%	0		22
23	V	10A	Therapy		Midwest Health Operations, LLC	100.00%	0		23
24	V	15	Mgmt. Allocation of Benefits		Midwest Health Operations, LLC	100.00%	0		24
25	V	17	Administrative		Midwest Health Operations, LLC	100.00%	0		25
26	V	19	Professional Services		Midwest Health Operations, LLC	100.00%	668	668	26
27	V	20	Dues, Fees, Subs & Promotions		Midwest Health Operations, LLC	100.00%	0		27
28	V	21	Clerical and General Office		Midwest Health Operations, LLC	100.00%	1,273	1,273	28
29	V	22	Employee Benefits & Payroll		Midwest Health Operations, LLC	100.00%	0		29
30	V	24	Travel and Seminar		Midwest Health Operations, LLC	100.00%	0		30
31	V	25	Other Admin. Staff Transport.		Midwest Health Operations, LLC	100.00%	0		31
32	V	26	Insurance-Prop./Liab./Malprac.		Midwest Health Operations, LLC	100.00%	0		32
33	V	27	Mgmt. Allocation of Benefits		Midwest Health Operations, LLC	100.00%	0		33
34	V	30	Depreciation		Midwest Health Operations, LLC	100.00%	0		34
35	V	32	Interest		Midwest Health Operations, LLC	100.00%	0		35
36	V	33	Real Estate Taxes		Midwest Health Operations, LLC	100.00%	0		36
37	V	34	Rent-Facility and Grounds		Midwest Health Operations, LLC	100.00%	0		37
38	V	35	Rent-Equipment & Vehicles		Midwest Health Operations, LLC	100.00%	0		38
39	Total			$			$ 1,941	$ * 1,941	39

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

Facility Name & ID Number Prairie City Health Care Center # 0050823 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

VII. RELATED PARTIES

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

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

Facility Name & ID Number Prairie City Health Care Center # 0050823 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

VII. RELATED PARTIES

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

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

Facility Name & ID Number Prairie City Health Care Center # 0050823 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

VII. RELATED PARTIES

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

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

Facility Name & ID Number Prairie City Health Care Center # 0050823 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			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 Prairie City Health Care Center # 0050823 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Prairie City Health Care Center # 0050823 Report Period Beginning: 1/1/2011 Ending: 2/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] 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 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	1,542,131	77	$ 311,109	$ 308,619	8,467	$ 1,708	1
2	2	Food	Resident Days	1,542,131	77	1,436	0	8,467	8	2
3	3	Housekeeping	Resident Days	1,542,131	77	2,014	0	8,467	11	3
4	4	Laundry	Resident Days	1,542,131	77	0	0	8,467	0	4
5	5	Utilities	Resident Days	1,542,131	77	20,347	0	8,467	112	5
6	6	Maintenance	Resident Days	1,542,131	77	126,852	100,385	8,467	696	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,542,131	77	70,933	0	8,467	389	7
8	10	Nursing and Medical Records	Resident Days	1,542,131	77	3,130	0	8,467	17	8
9	10A	Therapy	Resident Days	1,542,131	77	0	0	8,467	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,542,131	77	0	0	8,467	0	10
11	17	Administrative	Resident Days	1,542,131	77	4,905,497	4,905,497	8,467	60,647	11
12	19	Professional Services	Resident Days	1,542,131	77	355,921	0	8,467	1,954	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,542,131	77	25,013	0	8,467	137	13
14	21	Clerical and General Office	Resident Days	1,542,131	77	2,900,214	2,467,442	8,467	15,924	14
15	23	Inservice Training & Education	Resident Days	1,542,131	77	10,374	0	8,467	57	15
16	24	Travel and Seminar	Resident Days	1,542,131	77	3,057	0	8,467	17	16
17	25	Other Admin. Staff Transport.	Resident Days	1,542,131	77	266,518	0	8,467	1,463	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,542,131	77	72,152	0	8,467	396	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,542,131	77	1,178,815	0	8,467	6,472	19
20	30	Depreciation	Resident Days	1,542,131	77	416,712	0	8,467	2,288	20
21	32	Interest	Resident Days	1,542,131	77	501,565	0	8,467	2,754	21
22	33	Real Estate Taxes	Resident Days	1,542,131	77	25,635	0	8,467	141	22
23	34	Rent-Facility and Grounds	Resident Days	1,542,131	77	0	0	8,467	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,542,131	77	45,440	0	8,467	249	24
25	TOTALS					$ 11,242,734	$ 7,781,943		$ 95,440	25

Facility Name & ID Number Prairie City Health Care Center # 0050823 Report Period Beginning: 1/1/2011 Ending: 2/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Midwest 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 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	89,235	7	$	$	8,467	$	1
2	2	Food	Resident Days	89,235	7			8,467		2
3	3	Housekeeping	Resident Days	89,235	7			8,467		3
4	4	Laundry	Resident Days	89,235	7			8,467		4
5	5	Utilities	Resident Days	89,235	7			8,467		5
6	6	Maintenance	Resident Days	89,235	7			8,467		6
7	7	Mgmt. Allocation of Benefits	Resident Days	89,235	7			8,467		7
8	10	Nursing and Medical Records	Resident Days	89,235	7			8,467		8
9	10A	Therapy	Resident Days	89,235	7			8,467		9
10	15	Mgmt. Allocation of Benefits	Resident Days	89,235	7			8,467		10
11	17	Administrative	Resident Days	89,235	7			8,467		11
12	19	Professional Services	Resident Days	89,235	7	7,036		8,467	668	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	89,235	7			8,467		13
14	21	Clerical and General Office	Resident Days	89,235	7	13,414		8,467	1,273	14
15	22	Employee Benefits & Payroll	Resident Days	89,235	7			8,467		15
16	24	Travel and Seminar	Resident Days	89,235	7			8,467		16
17	25	Other Admin. Staff Transport.	Resident Days	89,235	7			8,467		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	89,235	7			8,467		18
19	27	Mgmt. Allocation of Benefits	Resident Days	89,235	7			8,467		19
20	30	Depreciation	Resident Days	89,235	7			8,467		20
21	32	Interest	Resident Days	89,235	7			8,467		21
22	33	Real Estate Taxes	Resident Days	89,235	7			8,467		22
23	34	Rent-Facility and Grounds	Resident Days	89,235	7			8,467		23
24	35	Rent-Equipment & Vehicles	Resident Days	89,235	7			8,467		24
25	TOTALS					$ 20,450	$		$ 1,941	25

Facility Name & ID Number Prairie City Health Care Center # 0050823 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Eddie Fransiscovich	X		Long-Term Working Capital		VAR	481,182	$ 127,325	10/2013	0.0700	$ 11,786	1
2	James Petersen	X		Long-Term Working Capital		VAR	45,000		Demand	None		2
3	Ipava Bank		X	Mortgage	$2,677.97	4/21/06	$ 320,000	271,569	4/21/16	0.0800	23,544	3
4												4
5								Disallowed Related Party Interest			(11,786)	5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$2,677.97		$ 846,182	$ 398,894			$ 23,544	9
	B. Non-Facility Related*											
10								Interest Income Offset			(922)	10
11								Home Office Allocation-PHC			2,754	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 1,832	14
15	TOTALS (line 9+line14)						$ 846,182	$ 398,894			$ 25,376	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.)

Facility Name & ID Number Prairie City Health Care Center # 0050823 **Report Period Beginning:** 1/1/2011 **Ending:** 12/31/2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**			$	4,500	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2010		$	4,616	2
3. Under or (over) accrual (line 2 minus line 1).			$	116	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)			$	4,800	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. **Home Office Allocation**		141			
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.			$	5,057	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006	4,359	8
	2007	4,435	9
	2008	4,511	10
	2009	4,390	11
	2010	4,616	12

Accrual based on prior year tax bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Prairie City Health Care Center COUNTY McDonough

FACILITY IDPH LICENSE NUMBER 0050823

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

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

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2010 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	15-000-022-05	Long-Term Care Facility	$ 4,616.32	$ 4,616.32
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 4,616.32	$ 4,616.32

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number Prairie City Health Care Center # 0050823 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 17,500 B. General Construction Type: Exterior Brick Frame Cinderblock Number of Stories 1

C. Does the Operating Entity? [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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 [X] NO
If so, please complete the following:

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	216,058	2008	$ 120,000	1
2					2
3	TOTALS	216,058		$ 120,000	3

Facility Name & ID Number Prairie City Health Care Center # 0050823 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	47		2008	1970	$ 562,500	$	25	$ 22,500	$ 22,500	$ 78,750	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Fire Alarm Control			2008	2,608		15	174	174	609	9
10	Patch Parking Lot			2009	3,200		7	458	458	1,145	10
11	Boiler Repair			2010	2,989		7	428	428	642	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	Land Improvements Booked					581			(581)		28
29	Building Booked					22,500			(22,500)		29
30	Building Improvement Booked					1,907			(1,907)		30
31											31
32											32
33	2011-Home Office Allocation-Land Improvements				376			24	24		33
34	2011-Home Office Allocation-Building Improvements				4,030			97	97		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

Facility Name & ID Number Prairie City Health Care Center # 0050823 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 575,703	$ 24,988		$ 23,681	$ (1,307)	$ 81,146	70

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

Facility Name & ID Number Prairie City Health Care Center # 0050823 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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	$ 116,629	$ 16,661	$ 11,663	$ (4,998)	10 yrs.	$ 52,483	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Home Office Allocation			2,167	2,167			74
75	TOTALS	$ 116,629	$ 16,661	$ 13,830	$ (2,831)		$ 52,483	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)	$ 812,332	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 41,649	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 37,511	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (4,138)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 133,629	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Prairie City Health Care Center # 0050823 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

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

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: $ 2,868 Description: See Attached Schedule 14A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18			N/A		18
19					19
20					20
21	TOTAL		$	$	21

* 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.

Prairie City Health Care Center
0050823

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

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	$	361
Dishwasher		-
Laundry Equipment		-
Copier		2,258
Home Office Allocation		249
		2,868

Facility Name & ID Number Prairie City Health Care Center # 0050823 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [ ] YES [X] NO

It is the policy of this facility to only hire certified nurses aides.

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

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

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.

Facility Name & ID Number Prairie City Health Care Center # 0050823 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A(3)	hrs	$	1,386	$ 20,795	$	1,386	$ 20,795	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		273	4,088		273	4,088	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		2,492	37,381		2,492	37,381	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				32,150		32,150	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			$	4,151	$ 62,264	$ 32,150	4,151	$ 94,414	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.

Facility Name & ID Number Prairie City Health Care Center **#** 0050823 **Report Period Beginning:** 1/1/2011 **Ending:** 12/31/2011

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2011 **(last day of reporting year)**

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 600	$ 600	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 5,000)	228,687	228,687	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	13,375	13,375	6
7	Other Prepaid Expenses	4,990	4,990	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 247,652	$ 247,652	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	125,050	120,000	13
14	Buildings, at Historical Cost	562,500	566,530	14
15	Leasehold Improvements, at Historical Cost	57,872	9,173	15
16	Equipment, at Historical Cost	116,629	116,629	16
17	Accumulated Depreciation (book methods)	(134,628)	(133,629)	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)**	$ 727,423	$ 678,703	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 975,075	$ 926,355	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 742,892	$ 742,892	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	31,879	31,879	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,997	2,997	31
32	Accrued Real Estate Taxes(Sch.IX-B)	4,800	4,800	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	30,310	30,310	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 812,878	$ 812,878	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	127,325	127,325	39
40	Mortgage Payable	271,569	271,569	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)**	$ 398,894	$ 398,894	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,211,772	$ 1,211,772	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (236,697)	$ (285,417)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 975,075	$ 926,355	48

***(See instructions.)**

Facility Name & ID Number Prairie City Health Care Center # 0050823 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (193,297)	1	
2	Restatements (describe):		2	
3	Rounding	2	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (193,295)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(88,402)	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) Owner Contributions	45,000	15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (43,402)	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)**	$ (236,697)	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number Prairie City Health Care Center # 0050823 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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

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

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 967,923	1
2	Discounts and Allowances for all Levels	(78,357)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 889,566	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	52,572	6
7	Oxygen	483	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 53,055	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	8,725	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	50,683	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	1,147	20
21	Other Medical Services	1,494	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 62,049	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	922	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 922	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	20	28
28a	Transportation Revenue	743	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 763	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,006,355	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	302,484	31
32	Health Care	450,345	32
33	General Administration	192,698	33
	B. Capital Expense		
34	Ownership	84,514	34
	C. Ancillary Expense		
35	Special Cost Centers	38,983	35
36	Provider Participation Fee	25,733	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,094,757	40
41	**Income before Income Taxes (line 30 minus line 40)****	(88,402)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (88,402)	43

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

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

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

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

Facility Name & ID Number Prairie City Health Care Center # 0050823 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,051	2,051	$ 43,303	$ 21.11	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,611	1,687	29,084	17.24	3
4	Licensed Practical Nurses	6,952	7,148	114,298	15.99	4
5	CNAs & Orderlies	13,862	14,684	129,380	8.81	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,547	1,581	15,807	10.00	9
10	Activity Assistants					10
11	Social Service Workers	667	731	7,689	10.52	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	25,187	12.11	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,220	7,535	63,254	8.39	15
16	Dishwashers					16
17	Maintenance Workers	1,357	1,497	19,664	13.14	17
18	Housekeepers	7,133	7,327	62,815	8.57	18
19	Laundry					19
20	Administrator	2,328	2,459	60,647	24.66	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					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 Ca Care Plan Coord	316	316	7,403	23.43	32
33	Other(specify) Transportation	210	210	1,995	9.50	33
34	TOTAL (lines 1 - 33)	47,334	49,306	$ 580,526 *	$ 11.77	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	6,000	L9, C3	36
37	Medical Records Consultant	2	50	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,524	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)	2	$ 7,574		49

C. CONTRACT NURSES

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

Facility Name & ID Number Prairie City Health Care Center # 0050823 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Gina Douglass	Administrator	0	$ 45,850
Beverly Haggerty	Administrator	0	14,797
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 60,647

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 68,400
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 68,400

C. Professional Services

Vendor/Payee	Type	Amount
E-Health Data Solutions	Computer Services	$ 3,485
Mediacom	Computer Services	1,312
Honkamp Krueger & Co.	Accounting Fees	103
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 4,900

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 14,159
Unemployment Compensation Insurance	16,142
FICA Taxes	38,724
Employee Health Insurance	15,877
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	257
Life Insurance	44
TOTAL (agree to Schedule V, line 22, col.8)	$ 85,203

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,130
Advertising: Employee Recruitment	1,048
Health Care Worker Background Check (Indicate # of checks performed)	
Patient Background Checks 61	614
Miscellaneous Licenses & Permits	728
Miscellaneous Dues & Subscriptions	22
Home Office Allocation	137
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,679

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Home Office Allocation	17
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 17

**See instructions.

Prairie City Health Care Center
0050823
Period Beginning **1/1/2011**
Period End **12/31/2011**

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	**Type**	**Amount**
Total (agree to Schedule V, line 19, column 3)		4,900
Home Office Allocation		
Heyl, Royster, Voelker & Allen	Legal	2
Henry County Recorder	Legal	
Ginoli & Company	Accountants	939
Miscellaneous Vendors	Computer Services	23
Advanced Answers on Demand	Computer Services	1,133
Access 2 Go	Computer Services	111
Kemper Technology	Computer Services	52
MediFax	Computer Services	18
VisionShare	Computer Services	80
Advanced System Design	Computer Services	104
Simple LTC	Computer Services	131
Optimizer Systems	Other Prof Fees	13
Clifton Gunderson	Other Prof Fees	5
Mike Miller	Other Prof Fees	6
OIC Group	Other Prof Fees	2
All Scripts	Other Prof Fees	3
Total (agree to Schedule V, line 19, column 8)		7,522

Facility Name & ID Number Prairie City Health Care Center # 0050823 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3	N/A												
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Prairie City Health Care Center # 0050823 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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? **N/A**
What was the average life used for new equipment added during this period? **N/A**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **3,941** 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. $ **25,733**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **N/A** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **8,725**

(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. $ **530**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Ginoli & Company**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees