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: 0046425

Facility Name: Sullivan Health Care Center

Address: 11 Hawthorne Ln. (Number) Sullivan (City) 61951 (Zip Code)

County: Moultrie

Telephone Number: (217) 728-4327 **Fax #** (217) 728-2263

HFS ID Number:

Date of Initial License for Current Owners: 12/01/1986

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			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 Sullivan Health Care Center # 0046425 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	123	Skilled (SNF)	123	44,895	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	123	TOTALS	123	44,895	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	11,938	4,225	2,376	18,539	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,938	4,225	2,376	18,539	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 41.29%

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)
Meals on Wheels

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 9/3/03

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 9/3/03 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 123 and days of care provided 2,177

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 Sullivan Health Care Center # 0046425 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	146,884	13,463		160,347		160,347	3,740	164,087			1
2	Food Purchase		121,044		121,044		121,044	(4,550)	116,494			2
3	Housekeeping	139,892	20,076		159,968		159,968	24	159,992			3
4	Laundry		2,700		2,700		2,700		2,700			4
5	Heat and Other Utilities			132,905	132,905		132,905	245	133,150			5
6	Maintenance	31,732	8,946	13,742	54,420		54,420	2,800	57,220			6
7	Other (specify):* Home Off. Ben. All.							853	853			7
8	**TOTAL General Services**	318,508	166,229	146,647	631,384		631,384	3,112	634,496			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	812,003	91,378	94,811	998,192		998,192	38	998,230			10
10a	Therapy	24,423	185	171,241	195,849		195,849		195,849			10a
11	Activities	20,430	834	875	22,139		22,139		22,139			11
12	Social Services	33,714	15		33,729		33,729		33,729			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Off. Ben. All.											15
16	**TOTAL Health Care and Programs**	890,570	92,412	278,927	1,261,909		1,261,909	38	1,261,947			16
	C. General Administration											
17	Administrative			170,000	170,000		170,000	(112,000)	58,000			17
18	Directors Fees											18
19	Professional Services			27,818	27,818		27,818	7,013	34,831			19
20	Dues, Fees, Subscriptions & Promotions			2,747	2,747		2,747	75	2,822			20
21	Clerical & General Office Expenses	25,830	4,233	6,949	37,012		37,012	40,068	77,080			21
22	Employee Benefits & Payroll Taxes			176,603	176,603		176,603		176,603			22
23	Inservice Training & Education			620	620		620	125	745			23
24	Travel and Seminar							37	37			24
25	Other Admin. Staff Transportation			2,194	2,194		2,194	6,622	8,816			25
26	Insurance-Prop.Liab.Malpractice			41,213	41,213		41,213	867	42,080			26
27	Other (specify):* Home Off. Ben. All.							14,171	14,171			27
28	**TOTAL General Administration**	25,830	4,233	428,144	458,207		458,207	(43,022)	415,185			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,234,908	262,874	853,718	2,351,500		2,351,500	(39,872)	2,311,628			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 Sullivan Health Care Center #0046425 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			55,167	55,167		55,167	51,491	106,658			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			188,254	188,254		188,254	37,113	225,367			32
33	Real Estate Taxes			43,349	43,349		43,349	308	43,657			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			17,643	17,643		17,643	548	18,191			35
36	Other (specify):*											36
37	**TOTAL Ownership**			304,413	304,413		304,413	89,460	393,873			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		118,687		118,687		118,687		118,687			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			67,343	67,343		67,343		67,343			42
43	Other (specify):* Non-allowable Costs		1,248	150,293	151,541		151,541	(151,541)				43
44	**TOTAL Special Cost Centers**		119,935	217,636	337,571		337,571	(151,541)	186,030			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,234,908	382,809	1,375,767	2,993,484		2,993,484	(101,953)	2,891,531			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 Sullivan Health Care Center # 0046425 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	(4,567)	2		4
5	Telephone, TV & Radio in Resident Rooms	(10,386)	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	33,218	30		9
10	Interest and Other Investment Income	(40)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(306)	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	2,284	43		18
19	Entertainment				19
20	Contributions	(450)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(127,414)	43		24
25	Fund Raising, Advertising and Promotional	(5,692)	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	(10,389)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (123,742)		$	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)	21,789	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 21,789		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (101,953)		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

Sullivan Health Care Center

ID# 0046425

Report Period Beginning: 1/1/2011

Ending: 12/31/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs-Part A	$ (5,751)	43	1
2	X-Rays-Part A	(1,958)	43	2
3	Resident Flowers	(972)	43	3
4	Disallowed Special Events	(31)	43	4
5	Offset Miscellaneous Office Supplies Revenue	(387)	21	5
6	Pet Expense	(865)	43	6
7	Offset Chamber of Commerce Dues	(425)	20	7
8				8
9				9
10				10
11				11
12				12
13				13
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42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(10,389)		49

Facility Name & ID Number Sullivan Health Care Center # 0046425 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%	$ 3,740	$ 3,740	1
2	V	2	Food		Petersen Health Care, Inc.	100.00%	17	17	2
3	V	3	Housekeeping		Petersen Health Care, Inc.	100.00%	24	24	3
4	V	4	Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5	Utilities		Petersen Health Care, Inc.	100.00%	245	245	5
6	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	1,525	1,525	6
7	V	7	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	853	853	7
8	V	10	Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	38	38	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	170,000	Petersen Health Care, Inc.	100.00%	58,000	(112,000)	11
12	V	19	Professional Services		Petersen Health Care, Inc.	100.00%	4,279	4,279	12
13	V								13
14	Total			$ 170,000			$ 68,721	$ * (101,279)	14

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

Facility Name & ID Number Sullivan Health Care Center # 0046425 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%	$ 301	$ 301	15
16	V	21	Clerical and General Office		Petersen Health Care, Inc.	100.00%	34,865	34,865	16
17	V	23	Inservice Training & Education		Petersen Health Care, Inc.	100.00%	125	125	17
18	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	37	37	18
19	V	25	Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	3,204	3,204	19
20	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	867	867	20
21	V	27	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	14,171	14,171	21
22	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	5,010	5,010	22
23	V	32	Interest		Petersen Health Care, Inc.	100.00%	6,030	6,030	23
24	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	308	308	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%	546	546	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			$			$ 65,464	$ * 65,464	39

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

Facility Name & ID Number Sullivan Health Care Center # 0046425 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	$	Petersen Health Care II, Inc.	100.00%	$ 0	$	15
16	V	2	Food		Petersen Health Care II, Inc.	100.00%	0		16
17	V	3	Housekeeping		Petersen Health Care II, Inc.	100.00%	0		17
18	V	4	Laundry		Petersen Health Care II, Inc.	100.00%	0		18
19	V	5	Utilities		Petersen Health Care II, Inc.	100.00%	0		19
20	V	6	Maintenance		Petersen Health Care II, Inc.	100.00%	1,275	1,275	20
21	V	7	Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	100.00%	0		21
22	V	10	Nursing and Medical Records		Petersen Health Care II, Inc.	100.00%	0		22
23	V	12	Social Services		Petersen Health Care II, Inc.	100.00%	0		23
24	V	17	Administrative		Petersen Health Care II, Inc.	100.00%	0		24
25	V	19	Professional Services		Petersen Health Care II, Inc.	100.00%	2,734	2,734	25
26	V	20	Dues, Fees, Subs & Promotions		Petersen Health Care II, Inc.	100.00%	199	199	26
27	V	21	Clerical and General Office		Petersen Health Care II, Inc.	100.00%	5,590	5,590	27
28	V	22	Employee Benefits & Payroll		Petersen Health Care II, Inc.	100.00%	0		28
29	V	23	Inservice Training & Education		Petersen Health Care II, Inc.	100.00%	0		29
30	V	24	Travel and Seminar		Petersen Health Care II, Inc.	100.00%	0		30
31	V	25	Other Admin. Staff Transport.		Petersen Health Care II, Inc.	100.00%	3,418	3,418	31
32	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care II, Inc.	100.00%	0		32
33	V	27	Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	100.00%	0		33
34	V	30	Depreciation		Petersen Health Care II, Inc.	100.00%	13,263	13,263	34
35	V	32	Interest		Petersen Health Care II, Inc.	100.00%	31,123	31,123	35
36	V	33	Real Estate Taxes		Petersen Health Care II, Inc.	100.00%	0		36
37	V	34	Rent-Facility and Grounds		Petersen Health Care II, Inc.	100.00%	0		37
38	V	35	Rent-Equipment & Vehicles		Petersen Health Care II, Inc.	100.00%	2	2	38
39	Total			$			$ 57,604	$ * 57,604	39

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

Facility Name & ID Number Sullivan Health Care Center # 0046425 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				1
2			Arcola Health Care Center	Arcola				2
3			Aspen Rehab & Health Care	Silvis				3
4			Batavia Rehab & Health Care Center	Batavia				4
5			Bement Health Care Center	Bement				5
6			Benton Rehab & Health Care Center	Benton				6
7			Bloomington Rehab & Health Care Center	Bloomington				7
8			Casey Health Care Center	Casey				8
9			Charleston Rehab & Health Care Center	Charleston				9
10			Cisne Rehab & Health Care Center	Cisne				10
11			Countryview Care Center of Macomb	Macomb				11
12			Countryview Terrace	Louisville				12
13			Cumberland Rehab & Health Care Center	Greenup				13
14			Decatur Rehab & Health Care Center	Decatur				14
15			Eastside Health & Rehabilitation Center	Pittsfield				15
16			Eastview Terrace	Sullivan				16
17			El Paso Health Care Center	El Paso				17
18			Enfield Rehab & Health Care Center	Enfield				18
19			Farmer City Rehab & Health Care Center	Farmer City				19
20			Flanagan Rehab & Health Care Center	Flanagan				20
21			Flora Gardens Care Center	Flora				21
22			Flora Health Care Center	Flora				22
23			Fondulac Rehab & Health Care Center	East Peoria				23
24			Havana Health Care Center	Havana				24
25			Illini Heritage Rehab & Health Care	Champaign				25
26			Jonesboro Rehab & Health Care Center	Jonesboro				26
27			Kewanee Care Home	Kewanee				27
28			LaHarpe Davier Health Care Center	LaHarpe				28
29			Lebanon Care Center	Lebanon				29
30			Marigold Rehab & Health Care Center	Galesburg				30

Facility Name & ID Number Sullivan Health Care Center # 0046425 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 Sullivan Health Care Center # 0046425 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								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 Sullivan Health Care Center # 0046425 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			Ozark Rehab & Health Care Center	Osage Beach, MO	Petersen Companies, LLC	Peoria	Mgmt/Bookkeeping	1
2			South Shore Health Care, LLC	Gary, IN	Petersen Health Care II, Inc.	Peoria	Mgmt/Bookkeeping	2
3			Cedargate Skilled Nursing Facility	Poplar Bluff, MO	Petersen Health Care, Inc.	Peoria	Mgmt/Bookkeeping	3
4			Tarkio Rehab & Health Care Center	Tarkio, MO	Petersen Health Enterprises, LLC	Peoria	Mgmt/Bookkeeping	4
5			Shangri-la Rehab & Living Center	Blue Springs, MO	Petersen Health Operations LLC	Peoria	Mgmt/Bookkeeping	5
6			Prairie Rose Care Center	Pana	Petersen Health Systems, Inc.	Peoria	Mgmt/Bookkeeping	6
7			Illini Heritage Rehab & Health Center	Champaign	Petersen Hotels LLC	Peoria	Hospitality	7
8			Courtyard Estates of Kewanee	Kewanee	Petersen Restaurants, LLC	Peoria	Restaurant	8
9			Courtyard Estates of Bradford	Bradford	Petersen Health Care IV, LLC	Peoria	Mgmt/Bookkeeping	9
10			Courtyard Estates of Galva	Galva	Petersen Health Care V, LLC	Peoria	Mgmt/Bookkeeping	10
11			Courtyard Estates of Walcott	Walcott	Petersen Health Care VI, LLC	Peoria	Mgmt/Bookkeeping	11
12			Courtyard Village of Kewanee	Kewanee	Petersen Health Care VII, LLC	Sullivan	Lessor	12
13			Lakewood Village	Charleston	Petersen Health Care VIII, LLC	Peoria	Mgmt/Bookkeeping	13
14			Courtyard Estates of Monmouth	Monmouth	Petersen Health Care X, LLC	Peoria	Lessor	14
15			Riverview Estates	Havana	Petersen Osage Beach, LLC	Osage Beach. MO	Lessor	15
16			Simple Blessings	Casey	Petersen West Frankfort, LLC	West Frankfort	Lessor	16
17			Courtyard Estates of Bushnell	Bushnell	Midwest Health Care, LLC	Peoria	Mgmt/Bookkeeping	17
18			Courtyard Estates of Canton	Canton	Poplar Bluff Health Care, LLC	Poplar Bluff, MO	Lessor	18
19			Legacy Estates of Monmouth	Monmouth	Petersen Roseville, LLC	Roseville	Lessor	19
20			Courtyard Estates of Sullivan	Sullivan				20
21			Courtyard Estates of Peoria	Peoria				21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Sullivan Health Care Center # 0046425 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 Sullivan Health Care Center # 0046425 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	18,539	$ 3,740	1
2	2	Food	Resident Days	1,542,131	77	1,436	0	18,539	17	2
3	3	Housekeeping	Resident Days	1,542,131	77	2,014	0	18,539	24	3
4	4	Laundry	Resident Days	1,542,131	77	0	0	18,539	0	4
5	5	Utilities	Resident Days	1,542,131	77	20,347	0	18,539	245	5
6	6	Maintenance	Resident Days	1,542,131	77	126,852	100,385	18,539	1,525	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,542,131	77	70,933	0	18,539	853	7
8	10	Nursing and Medical Records	Resident Days	1,542,131	77	3,130	0	18,539	38	8
9	10A	Therapy	Resident Days	1,542,131	77	0	0	18,539	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,542,131	77	0	0	18,539	0	10
11	17	Administrative	Resident Days	1,542,131	77	4,905,497	4,905,497	18,539	58,000	11
12	19	Professional Services	Resident Days	1,542,131	77	355,921	0	18,539	4,279	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,542,131	77	25,013	0	18,539	301	13
14	21	Clerical and General Office	Resident Days	1,542,131	77	2,900,214	2,467,442	18,539	34,865	14
15	23	Inservice Training & Education	Resident Days	1,542,131	77	10,374	0	18,539	125	15
16	24	Travel and Seminar	Resident Days	1,542,131	77	3,057	0	18,539	37	16
17	25	Other Admin. Staff Transport.	Resident Days	1,542,131	77	266,518	0	18,539	3,204	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,542,131	77	72,152	0	18,539	867	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,542,131	77	1,178,815	0	18,539	14,171	19
20	30	Depreciation	Resident Days	1,542,131	77	416,712	0	18,539	5,010	20
21	32	Interest	Resident Days	1,542,131	77	501,565	0	18,539	6,030	21
22	33	Real Estate Taxes	Resident Days	1,542,131	77	25,635	0	18,539	308	22
23	34	Rent-Facility and Grounds	Resident Days	1,542,131	77	0	0	18,539	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,542,131	77	45,440	0	18,539	546	24
25	TOTALS					$ 11,242,734	$ 7,781,943		$ 134,185	25

Facility Name & ID Number Sullivan Health Care Center # 0046425 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 II, Inc.
Street Address: 830 W. Trailcreek Drive
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 691-8113
Fax Number: (309) 691-8622

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	325,902	13	$	$	18,539	$	1
2	2	Food	Resident Days	325,902	13			18,539		2
3	3	Housekeeping	Resident Days	325,902	13			18,539		3
4	4	Laundry	Resident Days	325,902	13			18,539		4
5	5	Utilities	Resident Days	325,902	13			18,539		5
6	6	Maintenance	Resident Days	325,902	13	22,420		18,539	1,275	6
7	7	Mgmt. Allocation of Benefits	Resident Days	325,902	13			18,539		7
8	10	Nursing and Medical Records	Resident Days	325,902	13			18,539		8
9	15	Mgmt. Allocation of Benefits	Resident Days	325,902	13			18,539		9
10	17	Administrative	Resident Days	325,902	13			18,539		10
11	19	Professional Services	Resident Days	325,902	13	48,058		18,539	2,734	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	325,902	13	3,502		18,539	199	12
13	21	Clerical and General Office	Resident Days	325,902	13	98,273		18,539	5,590	13
14	22	Employee Benefits & Payroll	Resident Days	325,902	13			18,539		14
15	23	Inservice Training & Education	Resident Days	325,902	13			18,539		15
16	24	Travel and Seminar	Resident Days	325,902	13			18,539		16
17	25	Other Admin. Staff Transport.	Resident Days	325,902	13	60,087		18,539	3,418	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	325,902	13			18,539		18
19	27	Mgmt. Allocation of Benefits	Resident Days	325,902	13			18,539		19
20	30	Depreciation	Resident Days	325,902	13	233,155		18,539	13,263	20
21	32	Interest	Resident Days	325,902	13	547,113		18,539	31,123	21
22	33	Real Estate Taxes	Resident Days	325,902	13			18,539		22
23	34	Rent-Facility and Grounds	Resident Days	325,902	13			18,539		23
24	35	Rent-Equipment & Vehicles	Resident Days	325,902	13	36		18,539	2	24
25	TOTALS					$ 1,012,644	$		$ 57,604	25

Facility Name & ID Number Sullivan Health Care Center # 0046425 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	U.S. Bank		X	Mortgage	$40,714+ int.	12/10/04	$ 3,420,000	$ 2,721,602	12/10/11	0.0699	$ 188,254	1
2												2
3								Interest Income Offset			(40)	3
4								Home Office Allocation-PHC			6,030	4
5								Home Office Allocation-PHC II			31,123	5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 3,420,000	$ 2,721,602			$ 225,367	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 3,420,000	$ 2,721,602			$ 225,367	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 Sullivan Health Care Center # 0046425 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.**		$ 42,920	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2010	$ 42,469	2
3. Under or (over) accrual (line 2 minus line 1).		$ (451)	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 43,800	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** 308 **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.		$ 43,657	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006	43,102	8
	2007	41,554	9
	2008	41,471	10
	2009	42,056	11
	2010	42,469	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 Sullivan Health Care Center COUNTY Moultrie

FACILITY IDPH LICENSE NUMBER 0046425

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.	08-08-11-400-004	Long-Term Care Facility	$ 42,169.42	$ 42,169.42
2.	08-08-12-300-073	Long-Term Care Facility	$ 299.22	$ 299.22
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 42,468.64	$ 42,468.64

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 Sullivan Health Care Center # 0046425 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,000 B. General Construction Type: Exterior Brick & Block Frame Concrete 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	339,095	2003	$ 100,001	1
2					2
3	TOTALS	339,095		$ 100,001	3

Facility Name & ID Number Sullivan Health Care Center # 0046425 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	123		2003	1975	$ 1,560,545	$	39	$ 40,014	$ 40,014	$ 333,450	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Carpeting			2004	4,808		25	192	192	1,392	9
10	Fire Alarms			2004	1,524		25	61	61	417	10
11	Doors			2004	3,067		5			3,067	11
12	Smoke Alarms			2004	1,227		7	175	175	1,214	12
13	Land Improvements			2006	7,262		15	484	484	2,662	13
14	New Roof			2006	28,308		25	1,132	1,132	6,226	14
15	Kitchen Remodel			2006	22,241		25	890	890	4,895	15
16	Landscaping			2006	2,434		15	162	162	891	16
17	Sidewalks			2007	1,785		15	120	120	540	17
18	Sprinkler System			2008	14,839		25	594	594	2,079	18
19	Back Flow			2009	5,470		7	782	782	1,955	19
20	Water Heater			2009	2,983		5	596	596	1,490	20
21	Roof Repairs			2011	2,536		7	181	181	181	21
22											22
23											23
24											24
25											25
26											26
27											27
28	Land Improvements Booked					765			(765)		28
29	Building Booked					40,014			(40,014)		29
30	Building Improvement Booked					4,358			(4,358)		30
31											31
32											32
33											33
34	2011-Home Office Allocation-Building Improvements				8,824			212	212		34
35	2011-Home Office Allocation-Land Improvements				824			53	53		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 Sullivan Health Care Center # 0046425 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)		$ 1,668,677	$ 45,137		$ 45,648	$ 511	$ 360,459	70

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

Facility Name & ID Number Sullivan Health Care Center # 0046425 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	$ 648,731	$ 9,353	$ 42,500	$ 33,147	10 yrs.	$ 628,844	71
72	Current Year Purchases	4,740	677	237	(440)	10 yrs.	237	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			18,273	18,273			74
75	TOTALS	$ 653,471	$ 10,030	$ 61,010	$ 50,980		$ 629,081	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	2003 Ford	2003	$ 31,116	$		$		$ 31,116	76
77										77
78										78
79										79
80	TOTALS			$ 31,116	$	$	$		$ 31,116	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)	$ 2,453,265	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 55,167	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 106,658	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 51,491	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,020,656	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 Sullivan Health Care Center # 0046425 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: $ 18,191 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					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.

Sullivan Health Care Center
0046425

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	$	13,910
Dishwasher		-
Laundry Equipment		-
Copier		3,733
Home Office Allocation		548
		18,191

Facility Name & ID Number Sullivan Health Care Center # 0046425 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 Sullivan Health Care Center # 0046425 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	$	4,965	$ 74,478	$	4,965	$ 74,478	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,172	17,580		1,172	17,580	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		5,279	79,183	185	5,279	79,368	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				118,687		118,687	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			$	11,416	$ 171,241	$ 118,872	11,416	$ 290,113	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.

STATE OF ILLINOIS

Facility Name & ID Number Sullivan Health Care Center # 0046425 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	$ 3,128,174	$ 3,128,174	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 90,000)	597,318	597,318	3
4	Supply Inventory (priced at Cost)			4
5	Short-Term Investments			5
6	Prepaid Insurance	33,612	33,612	6
7	Other Prepaid Expenses	13,122	13,122	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Employee Education Loans	4,328	4,328	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,776,554	$ 3,776,554	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	111,481	100,001	13
14	Buildings, at Historical Cost	1,560,545	1,569,369	14
15	Leasehold Improvements, at Historical Cost	82,708	99,308	15
16	Equipment, at Historical Cost	688,882	684,587	16
17	Accumulated Depreciation (book methods)	(1,019,743)	(1,020,656)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,423,873	$ 1,432,609	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,200,427	$ 5,209,163	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 657,754	$ 657,754	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	85,586	85,586	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,583	2,583	31
32	Accrued Real Estate Taxes(Sch.IX-B)	43,800	43,800	32
33	Accrued Interest Payable	6,492	6,492	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	72,912	72,912	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 869,127	$ 869,127	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,721,602	2,721,602	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	A/P-Other	17,930	17,930	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,739,532	$ 2,739,532	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,608,659	$ 3,608,659	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,591,768	$ 1,600,504	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,200,427	$ 5,209,163	48

*(See instructions.)

Facility Name & ID Number Sullivan Health Care Center # 0046425 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**	$ 1,842,761	1
2	Restatements (describe):		2
3	Rounding	(1)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,842,760	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(250,992)	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)**	$ (250,992)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,591,768	24 *

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

Facility Name & ID Number Sullivan Health Care Center # 0046425 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	$ 2,457,678	1
2	Discounts and Allowances for all Levels	(354,410)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,103,268	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	396,971	6
7	Oxygen	3,600	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 400,571	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	4,567	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	216,785	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	7,984	20
21	Other Medical Services	8,890	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 238,226	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	40	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 40	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	387	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 387	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,742,492	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	631,384	31
32	Health Care	1,261,909	32
33	General Administration	458,207	33
	B. Capital Expense		
34	Ownership	304,413	34
	C. Ancillary Expense		
35	Special Cost Centers	270,228	35
36	Provider Participation Fee	67,343	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,993,484	40
41	**Income before Income Taxes (line 30 minus line 40)****	(250,992)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (250,992)	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 Sullivan Health Care Center # 0046425 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	1,982	2,009	$ 49,718	$ 24.75	1
2	Assistant Director of Nursing	2,040	2,040	42,026	20.60	2
3	Registered Nurses	3,035	3,091	73,938	23.92	3
4	Licensed Practical Nurses	12,541	12,850	251,581	19.58	4
5	CNAs & Orderlies	32,556	33,462	365,064	10.91	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,687	1,841	24,423	13.27	8
9	Activity Director	1,726	1,876	20,430	10.89	9
10	Activity Assistants					10
11	Social Service Workers	1,935	2,087	33,714	16.15	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	36,007	17.31	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,214	12,954	110,877	8.56	15
16	Dishwashers					16
17	Maintenance Workers	2,076	2,132	31,732	14.88	17
18	Housekeepers	14,921	15,432	139,892	9.07	18
19	Laundry					19
20	Administrator	2,080	2,080	58,000	27.88	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,080	2,080	25,830	12.42	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) CPC	1,112	1,257	29,676	23.61	33
34	TOTAL (lines 1 - 33)	94,065	97,271	$ 1,292,908 *	$ 13.29	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	12,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,388	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	16	715	L10a, C3	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	16	$ 16,103		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,312	$ 48,375	L10, C3	50
51	Licensed Practical Nurses	887	34,115	L10, C3	51
52	Certified Nurse Assistants/Aides	166	3,805	L10, C3	52
53	TOTAL (lines 50 - 52)	2,365	$ 86,295		53

Facility Name & ID Number Sullivan Health Care Center # 0046425 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Charles Pullen	Administrator	0	58,000
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 58,000

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 170,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 170,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
E-Health Data Solutions	Computer Services	$ 3,830
Mediacom	Computer Services	1,325
Honkamp, Krueger and Co.	Accounting Services	772
Allscripts	Accounting Services	637
Heyl, Royster, Voelker & Allen	Legal Services	21,120
Moultrie County Recorder	Filing Fees	134
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 27,818

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 37,591
Unemployment Compensation Insurance	17,697
FICA Taxes	92,896
Employee Health Insurance	24,829
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	1,506
Employee Retirement	1,931
Life Insurance	153
TOTAL (agree to Schedule V, line 22, col.8)	$ 176,603

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	$
Advertising: Employee Recruitment	458
Health Care Worker Background Check	
(Indicate # of checks performed 150)	
Patient Background Checks	1,504
Miscellaneous Licenses & Permits	360
Miscellaneous Dues & Subscriptions	425
Home Office Allocation	500
Less: Public Relations Expense	(425)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 2,822

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Home Office Allocation	37
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 37

**See instructions.

Sullivan Health Care Center
0046425
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)		27,818
Home Office Allocation		
Heyl, Royster, Voelker & Allen	Legal	4
Henry County Recorder	Legal	-
Ginoli & Company	Accountants	594
Miscellaneous Vendors	Computer Services	50
Advanced Answers on Demand	Computer Services	2,482
Access 2 Go	Computer Services	244
Kemper Technology	Computer Services	114
MediFax	Computer Services	38
VisionShare/Ability Network	Computer Services	175
Advanced System Design	Computer Services	229
Simple LTC	Computer Services	287
Optimizer Systems	Other Prof Fees	29
Clifton Gunderson	Other Prof Fees	10
Mike Miller	Other Prof Fees	14
OIC Group	Other Prof Fees	3
AllScripts	Other Prof Fees	7
Miscellaneous Vendors	Legal	2
Ginoli & Company	Accountants	982
U.S. Bank	Accountants	566
CDW	Computer Services	604
Polaris Group	Professional Fees	579
Total (agree to Schedule V, line 19, column 8)		34,831

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

Schedule 21B

XIX. SUPPORT SCHEDULE
Legal Fees

Facility

Vendor/Payee	Invoice Total	Allocation %	Total
Heyl, Royster, Voelker, and Allen	2,469.70	100%	2,470
Heyl, Royster, Voelker, and Allen	227.50	100%	228
Moultrie County Recorder	40.00	100%	40
Esquire Solutions	375.27	100%	375
Moultrie County Recorder	94.00	100%	94
Heyl, Royster, Voelker, and Allen	11,209.42	100%	11,209
Heyl, Royster, Voelker, and Allen	832.70	100%	833
Heyl, Royster, Voelker, and Allen	812.50	100%	813
Heyl, Royster, Voelker, and Allen	5,087.50	100%	5,088
Heyl, Royster, Voelker, and Allen	105.01	100%	105
Home Office Allocation			
Heyl, Royster, Voelker & Allen	375	1%	4
Miscellaneous Vendors	29	7%	2
Total Legal Fees			21,260

Facility Name & ID Number Sullivan Health Care Center # 0046425 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 Sullivan Health Care Center # 0046425 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? **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. $ **8,412** 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. $ **67,343**
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. $ **4,567**

(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. $ **0**
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? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees