FOR BHF USE

LL1

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: 0046847

Facility Name: Watseka Rehabilitation & Health Care Center

Address: 715 East Raymond Road (Number) Watseka (City) 60970 (Zip Code)

County: Iroquois

Telephone Number: (815) 432-5476 **Fax #** (815) 432-5669

HFS ID Number:

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

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 Watseka Rehabilitation & Health Care Center # 0046847 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	20,267	5,536	2,867	28,670	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,267	5,536	2,867	28,670	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.86%

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 1/1/2005

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 1/1/2005 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 2,624

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 Watseka Rehabilitation & Health Care Cente # 0046847 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	161,178	15,490		176,668		176,668	5,784	182,452			1
2	Food Purchase		164,730		164,730		164,730	(8,747)	155,983			2
3	Housekeeping	177,274	23,408		200,682		200,682	37	200,719			3
4	Laundry		16,187		16,187		16,187		16,187			4
5	Heat and Other Utilities			127,070	127,070		127,070	378	127,448			5
6	Maintenance	33,479	11,463	22,736	67,678		67,678	4,330	72,008			6
7	Other (specify):* Home Off. Ben. All.							1,319	1,319			7
8	TOTAL General Services	371,931	231,278	149,806	753,015		753,015	3,101	756,116			8
	B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	1,308,016	140,017	5,679	1,453,712		1,453,712	58	1,453,770			10
10a	Therapy		24	332,183	332,207		332,207		332,207			10a
11	Activities	129,564	1,079	100	130,743		130,743	(11,581)	119,162			11
12	Social Services	39,332			39,332		39,332		39,332			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Off. Ben. All.											15
16	TOTAL Health Care and Programs	1,476,912	141,120	345,162	1,963,194		1,963,194	(11,523)	1,951,671			16
	C. General Administration											
17	Administrative			228,000	228,000		228,000	(158,000)	70,000			17
18	Directors Fees											18
19	Professional Services			44,881	44,881		44,881	10,845	55,726			19
20	Dues, Fees, Subscriptions & Promotions			5,062	5,062		5,062	773	5,835			20
21	Clerical & General Office Expenses	29,179	6,349	8,843	44,371		44,371	61,885	106,256			21
22	Employee Benefits & Payroll Taxes			282,658	282,658		282,658		282,658			22
23	Inservice Training & Education			375	375		375	193	568			23
24	Travel and Seminar							57	57			24
25	Other Admin. Staff Transportation			24,059	24,059		24,059	10,241	34,300			25
26	Insurance-Prop.Liab.Malpractice			40,649	40,649		40,649	1,341	41,990			26
27	Other (specify):* Home Off. Ben. All.							21,916	21,916			27
28	TOTAL General Administration	29,179	6,349	634,527	670,055		670,055	(50,749)	619,306			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,878,022	378,747	1,129,495	3,386,264		3,386,264	(59,171)	3,327,093			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 Watseka Rehabilitation & Health Care Center #0046847 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			204,911	204,911		204,911	26,592	231,503			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			164,023	164,023		164,023	50,860	214,883			32
33	Real Estate Taxes			76,369	76,369		76,369	477	76,846			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			18,236	18,236		18,236	848	19,084			35
36	Other (specify):*											36
37	TOTAL Ownership			463,539	463,539		463,539	78,777	542,316			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		120,212		120,212		120,212		120,212			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	32,849	1,403	71,416	105,668		105,668	(105,668)				43
44	TOTAL Special Cost Centers	32,849	121,615	138,759	293,223		293,223	(105,668)	187,555			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,910,871	500,362	1,731,793	4,143,026		4,143,026	(86,062)	4,056,964			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 Watseka Rehabilitation & Health Care Center # 0046847 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	(8,774)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,194)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(1,666)	30		9
10	Interest and Other Investment Income	(6,595)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(612)	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	(1,835)	43		18
19	Entertainment				19
20	Contributions	(350)	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	(45,302)	43		24
25	Fund Raising, Advertising and Promotional	(3,583)	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	(60,051)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (134,962)		$	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)	48,900	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 48,900		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (86,062)		37

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

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

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

STATE OF ILLINOIS

Watseka Rehabilitation & Health Care Center

ID# 0046847

Report Period Beginning: 1/1/2011

Ending: 12/31/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs-Part A	$ (7,880)	43	1
2	X-Rays-Part A	(4,550)	43	2
3	Disallowed Special Events	201	43	3
4	Resident Flowers	(1,659)	43	4
5	Offset Miscellaneous Office Supplies Revenue	(678)	21	5
6	Pet Expense	(1,055)	43	6
7	Offset Transportation Revenue	(11,581)	11	7
8	Disallowed Marketing Salaries	(32,849)	43	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(60,051)		49

Facility Name & ID Number Watseka Rehabilitation & Health Care Center # 0046847 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%	$ 5,784	$ 5,784	1
2	V	2	Food		Petersen Health Care, Inc.	100.00%	27	27	2
3	V	3	Housekeeping		Petersen Health Care, Inc.	100.00%	37	37	3
4	V	4	Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5	Utilities		Petersen Health Care, Inc.	100.00%	378	378	5
6	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	2,358	2,358	6
7	V	7	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,319	1,319	7
8	V	10	Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	58	58	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	228,000	Petersen Health Care, Inc.	100.00%	70,000	(158,000)	11
12	V	19	Professional Services		Petersen Health Care, Inc.	100.00%	6,617	6,617	12
13	V								13
14	Total			$ 228,000			$ 86,578	$ * (141,422)	14

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

Facility Name & ID Number Watseka Rehabilitation & Health Care Center # 0046847 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%	$ 465	$ 465	15
16	V	21	Clerical and General Office		Petersen Health Care, Inc.	100.00%	53,918	53,918	16
17	V	23	Inservice Training & Education		Petersen Health Care, Inc.	100.00%	193	193	17
18	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	57	57	18
19	V	25	Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	4,955	4,955	19
20	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	1,341	1,341	20
21	V	27	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	21,916	21,916	21
22	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	7,747	7,747	22
23	V	32	Interest		Petersen Health Care, Inc.	100.00%	9,325	9,325	23
24	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	477	477	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%	845	845	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			$			$ 101,239	$ * 101,239	39

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

Facility Name & ID Number Watseka Rehabilitation & Health Care Center # 0046847 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%	1,972	1,972	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%	4,228	4,228	25
26	V	20	Dues, Fees, Subs & Promotions		Petersen Health Care II, Inc.	100.00%	308	308	26
27	V	21	Clerical and General Office		Petersen Health Care II, Inc.	100.00%	8,645	8,645	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%	5,286	5,286	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%	20,511	20,511	34
35	V	32	Interest		Petersen Health Care II, Inc.	100.00%	48,130	48,130	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%	3	3	38
39	Total			$			$ 89,083	$ * 89,083	39

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

Facility Name & ID Number Watseka Rehabilitation & Health Care Center # 0046847 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 Watseka Rehabilitation & Health Care Center # 0046847 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 Watseka Rehabilitation & Health Care Center # 0046847 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 Watseka Rehabilitation & Health Care Center # 0046847 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 Watseka Rehabilitation & Health Care Cent # 0046847 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 Watseka Rehabilitation & Health Care Center # 0046847 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	28,670	$ 5,784	1
2	2	Food	Resident Days	1,542,131	77	1,436	0	28,670	27	2
3	3	Housekeeping	Resident Days	1,542,131	77	2,014	0	28,670	37	3
4	4	Laundry	Resident Days	1,542,131	77	0	0	28,670	0	4
5	5	Utilities	Resident Days	1,542,131	77	20,347	0	28,670	378	5
6	6	Maintenance	Resident Days	1,542,131	77	126,852	100,385	28,670	2,358	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,542,131	77	70,933	0	28,670	1,319	7
8	10	Nursing and Medical Records	Resident Days	1,542,131	77	3,130	0	28,670	58	8
9	10A	Therapy	Resident Days	1,542,131	77	0	0	28,670	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,542,131	77	0	0	28,670	0	10
11	17	Administrative	Resident Days	1,542,131	77	4,905,497	4,905,497	28,670	70,000	11
12	19	Professional Services	Resident Days	1,542,131	77	355,921	0	28,670	6,617	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,542,131	77	25,013	0	28,670	465	13
14	21	Clerical and General Office	Resident Days	1,542,131	77	2,900,214	2,467,442	28,670	53,918	14
15	23	Inservice Training & Education	Resident Days	1,542,131	77	10,374	0	28,670	193	15
16	24	Travel and Seminar	Resident Days	1,542,131	77	3,057	0	28,670	57	16
17	25	Other Admin. Staff Transport.	Resident Days	1,542,131	77	266,518	0	28,670	4,955	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,542,131	77	72,152	0	28,670	1,341	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,542,131	77	1,178,815	0	28,670	21,916	19
20	30	Depreciation	Resident Days	1,542,131	77	416,712	0	28,670	7,747	20
21	32	Interest	Resident Days	1,542,131	77	501,565	0	28,670	9,325	21
22	33	Real Estate Taxes	Resident Days	1,542,131	77	25,635	0	28,670	477	22
23	34	Rent-Facility and Grounds	Resident Days	1,542,131	77	0	0	28,670	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,542,131	77	45,440	0	28,670	845	24
25	TOTALS					$ 11,242,734	$ 7,781,943		$ 187,817	25

Facility Name & ID Number Watseka Rehabilitation & Health Care Center # 0046847 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	$	$	28,670	$	1
2	2	Food	Resident Days	325,902	13			28,670		2
3	3	Housekeeping	Resident Days	325,902	13			28,670		3
4	4	Laundry	Resident Days	325,902	13			28,670		4
5	5	Utilities	Resident Days	325,902	13			28,670		5
6	6	Maintenance	Resident Days	325,902	13	22,420		28,670	1,972	6
7	7	Mgmt. Allocation of Benefits	Resident Days	325,902	13			28,670		7
8	10	Nursing and Medical Records	Resident Days	325,902	13			28,670		8
9	15	Mgmt. Allocation of Benefits	Resident Days	325,902	13			28,670		9
10	17	Administrative	Resident Days	325,902	13			28,670		10
11	19	Professional Services	Resident Days	325,902	13	48,058		28,670	4,228	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	325,902	13	3,502		28,670	308	12
13	21	Clerical and General Office	Resident Days	325,902	13	98,273		28,670	8,645	13
14	22	Employee Benefits & Payroll	Resident Days	325,902	13			28,670		14
15	23	Inservice Training & Education	Resident Days	325,902	13			28,670		15
16	24	Travel and Seminar	Resident Days	325,902	13			28,670		16
17	25	Other Admin. Staff Transport.	Resident Days	325,902	13	60,087		28,670	5,286	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	325,902	13			28,670		18
19	27	Mgmt. Allocation of Benefits	Resident Days	325,902	13			28,670		19
20	30	Depreciation	Resident Days	325,902	13	233,155		28,670	20,511	20
21	32	Interest	Resident Days	325,902	13	547,113		28,670	48,130	21
22	33	Real Estate Taxes	Resident Days	325,902	13			28,670		22
23	34	Rent-Facility and Grounds	Resident Days	325,902	13			28,670		23
24	35	Rent-Equipment & Vehicles	Resident Days	325,902	13	36		28,670	3	24
25	TOTALS					$ 1,012,644	$		$ 89,083	25

Facility Name & ID Number Watseka Rehabilitation & Health Care Cente # 0046847 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	US Bank		X	Mortgage	Varies	1/4/2005	$ 2,960,000	$ 2,355,538	12/18/2011	0.0690	$ 162,933	1
2												2
3								Interest Income Offset			(6,595)	3
4								Home Office Allocation-PHC			9,325	4
5								Home Office Allocation-PHC II			48,130	5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 2,960,000	$ 2,355,538			$ 213,793	9
	B. Non-Facility Related*											
10								Amortization of Loan Cost			1,090	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 1,090	14
15	TOTALS (line 9+line14)						$ 2,960,000	$ 2,355,538			$ 214,883	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 Watseka Rehabilitation & Health Care Center # 0046847 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.**		$ 77,820	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	$ 75,949	2
3. Under or (over) accrual (line 2 minus line 1).		$ (1,871)	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 78,240	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**		477	
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.		$ 76,846	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006	73,444	8
	2007	75,146	9
	2008	76,843	10
	2009	75,521	11
	2010	75,949	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 Watseka Rehabilitation & Health Care Center COUNTY Iroquois

FACILITY IDPH LICENSE NUMBER 0046847

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.	17-C-19-33-153-013	Long-Term Care Facility	$ 75,948.86	$ 75,948.86
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 75,948.86	$ 75,948.86

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 Watseka Rehabilitation & Health Care Center # 0046847 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 Steel 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	28,000	2005	$ 120,000	1
2					2
3	TOTALS	28,000		$ 120,000	3

Facility Name & ID Number Watseka Rehabilitation & Health Care Center # 0046847 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		2005	1976	$ 2,511,949	$	30	$ 83,732	$ 83,732	$ 586,123	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Parking lots, sidewalks & landscaping			2005	534,029		15	35,602	35,602	249,213	9
10	Sidewalks			2006	6,600		15	440	440	2,420	10
11	Roof			2007	7,678		15	512	512	2,304	11
12	Roof Repair			2008	3,276		39	84	84	294	12
13	Water Heater			2009	3,577		5	716	716	1,790	13
14	Water Heater			2009	2,885		5	578	578	1,445	14
15	Sprinkler Head Replacements			2010	22,838		15	1,522	1,522	2,283	15
16	Water Heater			2010	3,190		10	320	320	480	16
17	Roof Repair			2010	2,670		7	382	382	573	17
18	A/C Repair			2011	2,723		7	195	195	195	18
19	Wall and Roof Repair			2011	7,139		7	510	510	510	19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28	Land Improvements Booked					36,042			(36,042)		28
29	Building Booked					83,732			(83,732)		29
30	Building Improvement Booked					4,239			(4,239)		30
31											31
32	2011-Home Office Allocation-Building Improvements				13,646			327	327		32
33	2011-Home Office Allocation-Land Improvements				1,274			81	81		33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Watseka Rehabilitation & Health Care Center # 0046847 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)		$ 3,123,474	$ 124,013		$ 125,001	$ 988	$ 847,630	70

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

Facility Name & ID Number Watseka Rehabilitation & Health Care Center # 0046847 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	$ 784,888	$ 80,704	$ 78,489	$ (2,215)	5-10 yrs.	$ 534,917	71
72	Current Year Purchases	3,267	194	163	(31)	10 yrs.	163	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			27,850	27,850			74
75	TOTALS	$ 788,155	$ 80,898	$ 106,502	$ 25,604		$ 535,080	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	Resident	Bus	2005	$ 20,000	$	$	$		$ 20,000	76
77										77
78										78
79										79
80	TOTALS			$ 20,000	$	$	$		$ 20,000	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)	$ 4,051,629	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 204,911	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 231,503	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 26,592	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,402,710	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 Watseka Rehabilitation & Health Care Center # 0046847 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: $ 19,084 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.

Watseka Rehabilitation & Health Care Center
0046847
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	$	12,456
Dishwasher		708
Laundry Equipment		-
Copier		5,072
Home Office Allocation		848
		19,084

Facility Name & ID Number Watseka Rehabilitation & Health Care Center # 0046847 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 Watseka Rehabilitation & Health Care Center # 0046847 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		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	$	10,803	$ 162,047	$	10,803	$ 162,047	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2,378	35,676		2,378	35,676	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		8,964	134,460	24	8,964	134,484	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				120,212		120,212	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			$	22,145	$ 332,183	$ 120,236	22,145	$ 452,419	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 Watseka Rehabilitation & Health Care Center # 0046847 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	$ 1,012,689	$ 1,012,689	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 25,000)	861,254	861,254	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	34,143	34,143	6
7	Other Prepaid Expenses	15,231	15,231	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Employee Education Loans	512	512	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,923,829	$ 1,923,829	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	660,629	120,000	13
14	Buildings, at Historical Cost	2,511,949	2,525,595	14
15	Leasehold Improvements, at Historical Cost	55,976	597,879	15
16	Equipment, at Historical Cost	808,155	808,155	16
17	Accumulated Depreciation (book methods)	(1,412,802)	(1,402,710)	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 (spe **Goodwill**	257,851	257,851	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,881,758	$ 2,906,770	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,805,587	$ 4,830,599	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,265,295	$ 1,265,295	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	108,566	108,566	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,162	5,162	31
32	Accrued Real Estate Taxes(Sch.IX-B)	78,240	78,240	32
33	Accrued Interest Payable	5,619	5,619	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	90,126	90,126	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,553,008	$ 1,553,008	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,355,538	2,355,538	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,355,538	$ 2,355,538	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,908,546	$ 3,908,546	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 897,041	$ 922,053	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,805,587	$ 4,830,599	48

***(See instructions.)**

Facility Name & ID Number Watseka Rehabilitation & Health Care Center **#** 0046847 **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**	$ 759,190	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)**	$ 759,191	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	137,850	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)**	$ 137,850	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)**	$ 897,041	24 *

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

Facility Name & ID Number Watseka Rehabilitation & Health Care Center # 0046847 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	$ 3,797,027	1
2	Discounts and Allowances for all Levels	(315,613)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,481,414	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	498,697	6
7	Oxygen	2,283	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 500,980	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	8,774	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	243,028	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	20,200	20
21	Other Medical Services	7,626	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 279,628	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	6,595	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 6,595	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	678	28
28a	Transportation Revenue	11,581	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 12,259	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,280,876	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	753,015	31
32	Health Care	1,963,194	32
33	General Administration	670,055	33
	B. Capital Expense		
34	Ownership	463,539	34
	C. Ancillary Expense		
35	Special Cost Centers	225,880	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)***	$ 4,143,026	40
41	**Income before Income Taxes (line 30 minus line 40)****	137,850	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 137,850	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 Watseka Rehabilitation & Health Care Center # 0046847 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	2,080	2,080	$ 61,071	$ 29.36	1
2	Assistant Director of Nursing	2,921	2,921	76,210	26.09	2
3	Registered Nurses	3,313	3,371	91,611	27.18	3
4	Licensed Practical Nurses	18,109	18,977	385,085	20.29	4
5	CNAs & Orderlies	51,952	53,738	540,029	10.05	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,906	2,108	28,921	13.72	9
10	Activity Assistants	6,011	6,459	69,245	10.72	10
11	Social Service Workers	2,222	2,222	39,332	17.70	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	27,643	13.29	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,905	15,525	133,535	8.60	15
16	Dishwashers					16
17	Maintenance Workers	2,063	2,122	33,479	15.78	17
18	Housekeepers	16,369	17,054	177,274	10.39	18
19	Laundry					19
20	Administrator	2,080	2,080	70,000	33.65	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,983	2,163	29,179	13.49	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	1,626	1,784	18,007	10.09	31
32	Other Health Care(specify)					32
33	Other(specify) See Sch 20A	10,794	11,284	200,250	17.75	33
34	TOTAL (lines 1 - 33)	140,414	145,968	$ 1,980,871 *	$ 13.57	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	7,200	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	5,202	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	12	455	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)	12	$ 12,857		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

Watseka Rehabilitation & Health Care Center

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

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	4,449	4,763	111,102	23.33
Alzheimer's Coordinator	1,844	1,956	24,901	12.73
Transportation	2,421	2,080	31,398	15.10
Marketing	2,080	2,485	32,849	13.22
TOTAL	10,794	11,284	200,250	

Facility Name & ID Number Watseka Rehabilitation & Health Care Center # 0046847 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jeffrey Petersen	Administrator	0	$ 70,000
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 70,000

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 228,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 228,000
(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	1,317
Iroquis County Circuit Clerk	Filing Fees	256
Heyl, Royster, Voelker, & Allen	Legal Services	33,906
Sylvia Gerut	Legal Services	1,587
Area Wide Reporting Service	Legal Services	1,284
Honkamp Krueger & Co.	Accounting Services	386
Marilyn Mrozynski	Legal Services	1,478
Diligent Detective Agency	Legal Services	200
Allscripts	Computer Services	637
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 44,881

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 39,515
Unemployment Compensation Insurance	27,824
FICA Taxes	142,839
Employee Health Insurance	70,434
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	1,710
Life Insurance	336
TOTAL (agree to Schedule V, line 22, col.8)	$ 282,658

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	1,883
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks 238	2,384
Miscellaneous Licenses & Permits	795
Miscellaneous Dues & Subscriptions	0
Home Office Allocation	773
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,835

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Home Office Allocation	57
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 57

**See instructions.

Watseka Rehabilitation & Health Care Center
0046847
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)		44,881
Home Office Allocation		
Heyl, Royster, Voelker & Allen	Legal	7
Henry County Recorder	Legal	1
Ginoli & Company	Accountants	919
Miscellaneous Vendors	Computer Services	74
Advanced Answers on Demand	Computer Services	3,838
Access 2 Go	Computer Services	377
Kemper Technology	Computer Services	176
MediFax	Computer Services	59
VisionShare/Ability Network	Computer Services	270
Advanced System Design	Computer Services	353
Simple LTC	Computer Services	444
Optimizer Systems	Other Prof Fees	45
Clifton Gunderson	Other Prof Fees	16
Mike Miller	Other Prof Fees	22
OIC Group	Other Prof Fees	5
AllScripts	Other Prof Fees	12
Miscellaneous Vendors	Legal	3
Ginoli & Company	Accountants	1,519
U.S. Bank	Accountants	875
CDW	Computer Services	935
Polaris Group	Professional Fees	895
Total (agree to Schedule V, line 19, column 8)		55,726

Watseka Rehabilitation & Health Care Center

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 & Allen	2,280.21	100%	2,280
Heyl, Royster, Voelker & Allen	1,316.70	100%	1,317
Iroquois County Recorder	31.00	100%	31
Heyl, Royster, Voelker & Allen	350.00	100%	350
Sylvia Gerut Reporting	1,001.60	100%	1,002
Iroquois County Recorder	145.00	100%	145
Heyl, Royster, Voelker & Allen	2,388.33	100%	2,388
Heyl, Royster, Voelker & Allen	2,100.19	100%	2,100
Heyl, Royster, Voelker & Allen	10,929.79	100%	10,930
Area Wide Reporting Service	1,284.25	100%	1,284
Marilyn Mrozynski	1,478.31	100%	1,478
Iroquois County Recorder	80.00	100%	80
Heyl, Royster, Voelker & Allen	383.40	100%	383
Heyl, Royster, Voelker & Allen	9,295.62	100%	9,296
Sylvia Gerut Reporting	585.20	100%	585
Diligent Detective Agency	200.00	100%	200
Heyl, Royster, Voelker & Allen	87.50	100%	88
Heyl, Royster, Voelker & Allen	3,373.56	100%	3,374
Heyl, Royster, Voelker & Allen	70.00	100%	70
Heyl, Royster, Voelker & Allen	1,207.43	100%	1,207
Heyl, Royster, Voelker & Allen	87.50	100%	88
Heyl, Royster, Voelker & Allen	35.00	100%	35
Home Office Allocation			
Heyl, Royster, Voelker & Allen	375	1.87%	7
Henry County Recorder	41	2.43%	1
Miscellaneous Vendors	29	1.03%	3
Total Legal Fees			38,722

Facility Name & ID Number Watseka Rehabilitation & Health Care Center # 0046847 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 Watseka Rehabilitation & Health Care Center **#** 0046847 **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. $ **21,340** 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. $ **8,774**

(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. $ **9,962**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **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.