		FOR BHF USE					

LL1

DEPARTMI
FINANCIA

I. **IDPH License ID Number:** 0050625

Facility Name: Whispering Oaks

Address: 201 Spring Street (Number) Rosiclare (City)

County: Hardin

Telephone Number: (618)285-6974 **Fax #** (618) 289-4860

HFS ID Number:

Date of Initial License for Current Owners: 2/28/2006

Type of Ownership:

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

In the event there are further questions about this report, please contact:

Name: Mike Kocher **Telephone Number:** (309) 689-5850

Email Address:

IMPORTANT NOTICE

THIS AGENCY IS REQUESTING DISCLOSURE C
THAT IS NECESSARY TO ACCOMPLISH THE ST
PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. I
OF THIS INFORMATION IS MANDATORY. FAII
ANY INFORMATION ON OR BEFORE THE DUE
RESULT IN CESSATION OF PROGRAM PAYME
HAS BEEN APPROVED BY THE FORMS MANA

2013
STATE OF ILLINOIS
ENT OF HEALTHCARE AND FAMILY SERVICES
L AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

62982
Zip Code

ERNMENTAL
State
County
Other

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to t
State of Illinois, for the period from 1/1/2013 to
and certify to the best of my knowledge and belief that the said c
are true, accurate and complete statements in accordance with
applicable instructions. Declaration of preparer (other than prov
is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any informati
in this cost report may be punishable by fine and/or imprisonme

Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) Mark B. Petersen (Title) Chief Executive Officer
Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) ( ) Fax #

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phon

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DISCLOSURE
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Y SERVICES

e # (217) 782-1630

Facility Name & ID Number Whispering Oaks

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		Skilled (SNF)		
2		Skilled Pediatric (SNF/PED)		
3		Intermediate (ICF)		
4		Intermediate/DD		
5		Sheltered Care (SC)		
6	16	ICF/DD 16 or Less	16	5,840
7	16	TOTALS	16	5,840

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				
9	SNF/PED				
10	ICF				
11	ICF/DD				
12	SC				
13	DD 16 OR LESS	4,250			4,250
14	TOTALS	4,250			4,250

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.77%

0050625 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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 [ ]

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 2/28/2006

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

YES [X] Date 2/28/2006 NO [ ]

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

YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2013 Fiscal Year: 12/31/2013

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

Facility Name & ID Number Whispering Oaks #

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

	Operating Expenses	Costs Per General Ledger			
		Salary/Wage	Supplies	Other	Total
	A. General Services	1	2	3	4
1	Dietary	25,497	1,863	1,166	28,526
2	Food Purchase		18,780		18,780
3	Housekeeping		2,089		2,089
4	Laundry		1,519		1,519
5	Heat and Other Utilities			13,631	13,631
6	Maintenance		873	4,273	5,146
7	Other (specify):* Home Off. Ben. All.				
8	**TOTAL General Services**	25,497	25,124	19,070	69,691
	B. Health Care and Programs				
9	Medical Director			3,600	3,600
10	Nursing and Medical Records	149,015	11,067	2,514	162,596
10a	Therapy				
11	Activities		58	415	473
12	Social Services	22,617			22,617
13	CNA Training				
14	Program Transportation				
15	Other (specify):* Home Off. Ben. All.				
16	**TOTAL Health Care and Programs**	171,632	11,125	6,529	189,286
	C. General Administration				
17	Administrative			63,200	63,200
18	Directors Fees				
19	Professional Services			4,924	4,924
20	Dues, Fees, Subscriptions & Promotions			112	112
21	Clerical & General Office Expenses		787	6,127	6,914
22	Employee Benefits & Payroll Taxes			50,509	50,509
23	Inservice Training & Education			307	307
24	Travel and Seminar				
25	Other Admin. Staff Transportation			3,208	3,208
26	Insurance-Prop.Liab.Malpractice			7,421	7,421
27	Other (specify):* Home Off. Ben. All.				
28	**TOTAL General Administration**		787	135,808	136,595
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	197,129	37,036	161,407	395,572

***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 includ

0050625 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	28,526	546	29,072			1
	18,780	18	18,798			2
	2,089	8	2,097			3
	1,519		1,519			4
	13,631	64	13,695			5
	5,146	410	5,556			6
		47	47			7
	69,691	1,093	70,784			8
	3,600		3,600			9
	162,596	3	162,599			10
						10a
	473		473			11
	22,617	(4,681)	17,936			12
						13
						14
						15
	189,286	(4,678)	184,608			16
	63,200	(28,200)	35,000			17
						18
	4,924	2,982	7,906			19
	112	147	259			20
	6,914	11,542	18,456			21
	50,509		50,509			22
	307	17	324			23
		1	1			24
	3,208	775	3,983			25
	7,421	150	7,571			26
		961	961			27
	136,595	(11,625)	124,970			28
	395,572	(15,210)	380,362			29

e a detailed explanation of each reclassification.

Facility Name & ID Number **Whispering Oaks**

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger			
		Salary/Wage	Supplies	Other	Total
	D. Ownership	1	2	3	4
30	Depreciation			22,640	22,640
31	Amortization of Pre-Op. & Org.			2,058	2,058
32	Interest			28,297	28,297
33	Real Estate Taxes			5,118	5,118
34	Rent-Facility & Grounds				
35	Rent-Equipment & Vehicles			6,185	6,185
36	Other (specify):*				
37	**TOTAL Ownership**			64,298	64,298
	Ancillary Expense				
	E. Special Cost Centers				
38	Medically Necessary Transportation				
39	Ancillary Service Centers				
40	Barber and Beauty Shops				
41	Coffee and Gift Shops				
42	Provider Participation Fee			29,612	29,612
43	Other (specify):* **Non-allowable Costs**		125	9,816	9,941
44	**TOTAL Special Cost Centers**		125	39,428	39,553
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	197,129	37,161	265,133	499,423

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $100**

Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	22,640	5,187	27,827			30
	2,058		2,058			31
	28,297	27,011	55,308			32
	5,118	67	5,185			33
						34
	6,185	163	6,348			35
						36
	64,298	32,428	96,726			37
						38
						39
						40
						41
	29,612		29,612			42
	9,941	(9,941)				43
	39,553	(9,941)	29,612			44
	499,423	7,277	506,700			45

0.

Facility Name & ID Number Whispering Oaks # 0050625

VI. ADJUSTMENT DETAIL **A. The expenses indicated below are non-allowable and should**
In column 2 below, reference the line on which the particula

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY
1	Day Care	$		$
2	Other Care for Outpatients			
3	Governmental Sponsored Special Programs			
4	Non-Patient Meals	(291)	2	
5	Telephone, TV & Radio in Resident Rooms	(1,124)	43	
6	Rented Facility Space			
7	Sale of Supplies to Non-Patients			
8	Laundry for Non-Patients			
9	Non-Straightline Depreciation	4,457	30	
10	Interest and Other Investment Income			
11	Discounts, Allowances, Rebates & Refunds			
12	Non-Working Officer's or Owner's Salary			
13	Sales Tax	(5)	43	
14	Non-Care Related Interest			
15	Non-Care Related Owner's Transactions			
16	Personal Expenses (Including Transportation)			
17	Non-Care Related Fees			
18	Fines and Penalties	(3,705)	43	
19	Entertainment			
20	Contributions			
21	Owner or Key-Man Insurance			
22	Special Legal Fees & Legal Retainers			
23	Malpractice Insurance for Individuals			
24	Bad Debt	(3,000)	43	
25	Fund Raising, Advertising and Promotional	(485)	43	
26	Income Taxes and Illinois Personal Property Replacement Tax			
27	CNA Training for Non-Employees			
28	Yellow Page Advertising			
29	Other-Attach Schedule See Page 5A	(6,303)	Various	
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (10,456)		$

BHF USE ONLY									
48		49		50		51		52	

be adjusted out of Schedule V, pages 3 or 4 via column 7.
r cost was included. (See instructions.)

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)		17,733	Various	34
35	Other- Attach Schedule				35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$	17,733		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$	7,277		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

Whispering Oaks

ID# 0050625

Report Period Beginning: 1/1/2013

Ending: 12/31/2013

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Offset Transportation Revenue	(4,681)	12	1
2	Disallowed Special Events	45	43	2
3	Disallowed Air Travel Expense	(1,667)	43	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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21				21
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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**	(6,303)		49

Facility Name & ID Number Whispering Oaks

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE
	A. General Services	**5 & 5A**	**6**	**6A**	**6B**
1	Dietary	**0**	**837**	**0**	**0**
2	Food Purchase	**0**	**18**	**0**	**0**
3	Housekeeping	**0**	**8**	**0**	**0**
4	Laundry	**0**	**0**	**0**	**0**
5	Heat and Other Utilities	**0**	**64**	**0**	**0**
6	Maintenance	**0**	**410**	**0**	**0**
7	Other (specify):*	**0**	**47**	**0**	**0**
8	**TOTAL General Services**	**0**	**1,384**	**0**	**0**
	B. Health Care and Programs				
9	Medical Director	**0**	**0**	**0**	**0**
10	Nursing and Medical Records	**0**	**3**	**0**	**0**
10a	Therapy	**0**	**0**	**0**	**0**
11	Activities	**0**	**0**	**0**	**0**
12	Social Services	**(4,681)**	**0**	**0**	**0**
13	CNA Training	**0**	**0**	**0**	**0**
14	Program Transportation	**0**	**0**	**0**	**0**
15	Other (specify):*	**0**	**0**	**0**	**0**
16	**TOTAL Health Care and Programs**	**(4,681)**	**3**	**0**	**0**
	C. General Administration				
17	Administrative	**0**	**(28,200)**	**0**	**0**
18	Directors Fees	**0**	**0**	**0**	**0**
19	Professional Services	**0**	**1,766**	**0**	**0**
20	Fees, Subscriptions & Promotions	**0**	**0**	**112**	**1,216**
21	Clerical & General Office Expenses	**0**	**0**	**10,379**	**35**
22	Employee Benefits & Payroll Taxes	**0**	**0**	**0**	**1,163**
23	Inservice Training & Education	**0**	**0**	**17**	**0**
24	Travel and Seminar	**0**	**0**	**1**	**0**
25	Other Admin. Staff Transportation	**0**	**0**	**775**	**0**
26	Insurance-Prop.Liab.Malpractice	**0**	**0**	**150**	**0**
27	Other (specify):*	**0**	**0**	**961**	**0**
28	**TOTAL General Administration**	**0**	**(26,434)**	**12,395**	**2,414**
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	**(4,681)**	**(25,047)**	**12,395**	**2,414**

STATE OF ILLINOIS

0050625 Report Period Beginning: 1/1/2013 Ending:

PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
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0	0	0	0	0	0	0

Summary A
12/31/2013

SUMMARY TOTALS (to Sch V, col.7)	
837	1
18	2
8	3
0	4
64	5
410	6
47	7
1,384	8
0	9
3	10
0	10a
0	11
(4,681)	12
0	13
0	14
0	15
(4,678)	16
(28,200)	17
0	18
1,766	19
1,328	20
10,414	21
1,163	22
17	23
1	24
775	25
150	26
961	27
(11,625)	28
(14,919)	29

STATE OF ILLINOIS

Facility Name & ID Number **Whispering Oaks**

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE
	D. Ownership	**5 & 5A**	**6**	**6A**	**6B**
30	Depreciation	**(1,124)**	**0**	**688**	**42**
31	Amortization of Pre-Op. & Org.	**0**	**0**	**0**	**0**
32	Interest	**0**	**0**	**1,145**	**25,866**
33	Real Estate Taxes	**0**	**0**	**67**	**0**
34	Rent-Facility & Grounds	**0**	**0**	**0**	**0**
35	Rent-Equipment & Vehicles	**0**	**0**	**124**	**39**
36	Other (specify):*	**0**	**0**	**0**	**0**
37	**TOTAL Ownership**	**(1,124)**	**0**	**2,024**	**25,947**
	Ancillary Expense				
	E. Special Cost Centers				
38	Medically Necessary Transportation	**0**	**0**	**0**	**0**
39	Ancillary Service Centers	**0**	**0**	**0**	**0**
40	Barber and Beauty Shops	**0**	**0**	**0**	**0**
41	Coffee and Gift Shops	**0**	**0**	**0**	**0**
42	Provider Participation Fee	**0**	**0**	**0**	**0**
43	Other (specify):*	**2,835**	**0**	**0**	**0**
44	**TOTAL Special Cost Centers**	**2,835**	**0**	**0**	**0**
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	**(2,970)**	**(25,047)**	**14,419**	**28,361**

 # 0050625 Report Period Beginning: 1/1/2013 Ending:

PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
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0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0

Summary B
12/31/2013

SUMMARY TOTALS (to Sch V, col.7)	
(394)	30
0	31
27,011	32
67	33
0	34
163	35
0	36
26,847	37
0	38
0	39
0	40
0	41
0	42
2,835	43
2,835	44
14,763	45

Facility Name & ID Number Whispering Oaks

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defin

1 OWNERS		2 RELATED NURSI
Name	**Ownership %**	**Name**
Mark B. Petersen	100	See PG6 - Supp

B. Are any costs included in this report which are a result of transactions with related organizations? management fees, purchase of supplies, and so forth. [X] YES [ ]

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in 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 Or Name of Related O
1	V		1	Dietary	$	Petersen Health Ca
2	V		2	Food		Petersen Health Ca
3	V		3	Housekeeping		Petersen Health Ca
4	V		4	Laundry		Petersen Health Ca
5	V		5	Utilities		Petersen Health Ca
6	V		6	Maintenance		Petersen Health Ca
7	V		7	Mgmt. Allocation of Benefits		Petersen Health Ca
8	V		10	Nursing and Medical Records		Petersen Health Ca
9	V		10A	Therapy		Petersen Health Ca
10	V		15	Mgmt. Allocation of Benefits		Petersen Health Ca
11	V		17	Administrative	63,200	Petersen Health Ca
12	V		19	Professional Services		Petersen Health Ca
13	V					
14	Total				$ 63,200	

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

ed in the instructions. Use Page 6-Supplemental as necessary.

		3		
NG HOMES		OTHER RELATED BUSINESS ENTITIES		
	City	Name	City	Type of Busine
		See PG6 - Supp		

This includes rent,
NO

accordance with

ganization	6	7	8 Difference:
rganization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
ıre, Inc.	100.00%	$ 837	$ 837
ıre, Inc.	100.00%	18	18
ıre, Inc.	100.00%	8	8
ıre, Inc.	100.00%	0	
ıre, Inc.	100.00%	64	64
ıre, Inc.	100.00%	410	410
ıre, Inc.	100.00%	47	47
ıre, Inc.	100.00%	3	3
ıre, Inc.	100.00%	0	
ıre, Inc.	100.00%	0	
ıre, Inc.	100.00%	35,000	(28,200)
ıre, Inc.	100.00%	1,766	1,766
		$ 38,153	$ * (25,047)

ess

1
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13
14

Facility Name & ID Number Whispering Oaks

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? T
management fees, purchase of supplies, and so forth. [X] YES [ ]

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in a
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 Org Name of Related O
15	V	20	Dues, Fees, Subs & Promotions	$	Petersen Health Care
16	V	21	Clerical and General Office		Petersen Health Care
17	V	23	Inservice Training & Education		Petersen Health Care
18	V	24	Travel and Seminar		Petersen Health Care
19	V	25	Other Admin. Staff Transport.		Petersen Health Care
20	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care
21	V	27	Mgmt. Allocation of Benefits		Petersen Health Care
22	V	30	Depreciation		Petersen Health Care
23	V	32	Interest		Petersen Health Care
24	V	33	Real Estate Taxes		Petersen Health Care
25	V	34	Rent-Facility and Grounds		Petersen Health Care
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care
27	V				
28	V				
29	V				
30	V				
31	V				
32	V				
33	V				
34	V				
35	V				
36	V				
37	V				
38	V				
39	Total			$	

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

This includes rent,
NO

accordance with

ganization	6	7	8 Difference:
rganization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
, Inc.	100.00%	$ 112	$ 112
, Inc.	100.00%	10,379	10,379
, Inc.	100.00%	17	17
, Inc.	100.00%	1	1
, Inc.	100.00%	775	775
, Inc.	100.00%	150	150
, Inc.	100.00%	961	961
, Inc.	100.00%	688	688
, Inc.	100.00%	1,145	1,145
, Inc.	100.00%	67	67
, Inc.	100.00%	0	
, Inc.	100.00%	124	124
		$ 14,419	$ * 14,419

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Facility Name & ID Number Whispering Oaks

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? T
management fees, purchase of supplies, and so forth. [X] YES [ ]

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in a
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 Org Name of Related O
15	V	1	Dietary	$	Petersen Health Netw
16	V	2	Food		Petersen Health Netw
17	V	3	Housekeeping		Petersen Health Netw
18	V	4	Laundry		Petersen Health Netw
19	V	5	Utilities		Petersen Health Netw
20	V	6	Maintenance		Petersen Health Netw
21	V	7	Mgmt. Allocation of Benefits		Petersen Health Netw
22	V	10	Nursing and Medical Records		Petersen Health Netw
23	V	12	Social Services		Petersen Health Netw
24	V	17	Administrative		Petersen Health Netw
25	V	19	Professional Services		Petersen Health Netw
26	V	20	Dues, Fees, Subs & Promotions		Petersen Health Netw
27	V	21	Clerical and General Office		Petersen Health Netw
28	V	22	Employee Benefits & Payroll		Petersen Health Netw
29	V	23	Inservice Training & Education		Petersen Health Netw
30	V	24	Travel and Seminar		Petersen Health Netw
31	V	25	Other Admin. Staff Transport.		Petersen Health Netw
32	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Netw
33	V	27	Mgmt. Allocation of Benefits		Petersen Health Netw
34	V	30	Depreciation		Petersen Health Netw
35	V	32	Interest		Petersen Health Netw
36	V	33	Real Estate Taxes		Petersen Health Netw
37	V	34	Rent-Facility and Grounds		Petersen Health Netw
38	V	35	Rent-Equipment & Vehicles		Petersen Health Netw
39	Total			$	

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

This includes rent,
NO

accordance with

ganization	6	7	8 Difference:
rganization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
ork, LLC	100.00%	$ 0	$
ork, LLC	100.00%	0	
ork, LLC	100.00%	0	
ork, LLC	100.00%	0	
ork, LLC	100.00%	0	
ork, LLC	100.00%	0	
ork, LLC	100.00%	0	
ork, LLC	100.00%	0	
ork, LLC	100.00%	0	
ork, LLC	100.00%	0	
ork, LLC	100.00%	0	
ork, LLC	100.00%	1,216	1,216
ork, LLC	100.00%	35	35
ork, LLC	100.00%	1,163	1,163
ork, LLC	100.00%	0	
ork, LLC	100.00%	0	
ork, LLC	100.00%	0	
ork, LLC	100.00%	0	
ork, LLC	100.00%	0	
ork, LLC	100.00%	42	42
ork, LLC	100.00%	25,866	25,866
ork, LLC	100.00%	0	
ork, LLC	100.00%	0	
ork, LLC	100.00%	39	39
		$ 28,361	$ * 28,361

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Facility Name & ID Number **Whispering Oaks**

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizat**

	1 OWNERS		2 RELATED NU
	Name	**Ownership %**	**Name**
1			**Aledo Health Care Center**
2			**Arcola Health Care Center**
3			**Aspen Rehab & Health Care**
4			**Batavia Rehab & Health Care Cent**
5			**Bement Health Care Center**
6			**Benton Rehab & Health Care Cent**
7			**Bloomington Rehab & Health Care**
8			**Casey Health Care Center**
9			**Charleston Rehab & Health Care C**
10			**Cisne Rehab & Health Care Center**
11			**Countryview Care Center of Macon**
12			**Countryview Terrace**
13			**Cumberland Rehab & Health Care**
14			**Decatur Rehab & Health Care Cen**
15			**Eastside Health & Rehabilitation C**
16			**Eastview Terrace**
17			**El Paso Health Care Center**
18			**Enfield Rehab & Health Care Cent**
19			**Farmer City Rehab & Health Care**
20			**Flanagan Rehab & Health Care Ce**
21			**Flora Gardens Care Center**
22			**Flora Health Care Center**
23			**Fondulac Rehab & Health Care Ce**
24			**Havana Health Care Center**
25			**Illini Heritage Rehab & Health Car**
26			**Jonesboro Rehab & Health Care C**
27			**Kewanee Care Home**
28			**LaHarpe Davier Health Care Cente**
29			**Lebanon Care Center**
30			**Marigold Rehab & Health Care Ce**

tions (parties) as defined in the instructions.

JRSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
	City	Name	City	Type of Business
	Aledo	Petersen Companies, L	Peoria	Mgmt/Bookkeeping
	Arcola	Petersen Health Care I	Peoria	Mgmt/Bookkeeping
	Silvis	Petersen Health Care,	Peoria	Mgmt/Bookkeeping
ter	Batavia	Petersen Health Enterp	Peoria	Mgmt/Bookkeeping
	Bement	Petersen Health Opera	Peoria	Mgmt/Bookkeeping
er	Benton	Petersen Health Systen	Peoria	Mgmt/Bookkeeping
Center	Bloomington	Petersen Hotels LLC	Peoria	Hospitality
	Casey	Petersen Restaurants, I	Peoria	Restaurant
Center	Charleston	Petersen Health Care I	Peoria	Mgmt/Bookkeeping
	Cisne	Petersen Health Care V	Peoria	Mgmt/Bookkeeping
mb	Macomb	Petersen Health Care V	Peoria	Mgmt/Bookkeeping
	Louisville	Petersen Health Care V	Sullivan	Lessor
Center	Greenup	Petersen Health Care V	Peoria	Mgmt/Bookkeeping
ter	Decatur	Petersen Health Care X	Peoria	Lessor
enter	Pittsfield	Petersen Osage Beach,	Osage Beach. MO	Lessor
	Sullivan	Petersen West Frankfo	West Frankfort	Lessor
	El Paso	Midwest Health Care, I	Peoria	Mgmt/Bookkeeping
er	Enfield	Poplar Bluff Health Ca	Poplar Bluff, MO	Lessor
Center	Farmer City	Petersen Roseville, LL	Roseville	Lessor
nter	Flanagan			
	Flora			
	Flora			
nter	East Peoria			
	Havana			
re	Champaign			
enter	Jonesboro			
	Kewanee			
er	LaHarpe			
	Lebanon			
nter	Galesburg			

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Facility Name & ID Number **Whispering Oaks**

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizat**

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

tions (parties) as defined in the instructions.

URSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
	City	Name	City	Type of Business
	Sullivan			
e Center	McLeansboro			
	Mt. Vernon			
nter	Newman			
nter	Nokomis			
	North Aurora			
re Center	Princeton			
	Mattoon			
	Piper City			
e Center	Morrison			
Center	Polo			
Center	Prairie City			
	Brighton			
	Rochelle			
nter	Rochelle			
enter	Rock Falls			
	Rock Falls			
Center	Roseville			
nter	Rosiclare			
	Kewanee			
enter	Sandwich			
	Sandwich			
	Harrisburg			
Center	Shelbyville			
Center	South Elgin			
	Watseka			
	Sullivan			
	Canton			
	Swansea			
er	Pekin			

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Facility Name & ID Number **Whispering Oaks**

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizat**

	1 OWNERS		2 RELATED NU
	Name	**Ownership %**	**Name**
1			**Toulon Health Care Center**
2			**Tuscola Health Care Center**
3			**Twin Lakes Rehab & Health Care**
4			**Vandalia Rehab & Health Care Ce**
5			**Watseka Health Care Center**
6			**Westside Rehab & Care Center**
7			**Whispering Oaks**
8			**White Oak Rehab & Health Care C**
9			**Willow Rose Rehab & Health Care**
10			**Sheldon Health Care Center**
11			**Tuscola Health Care Center**
12			**Effingham Health Care Center**
13			**Collinsville Health Care Center**
14			**Ozark Rehab & Health Care Cente**
15			**South Shore Health Care, LLC**
16			**Cedargate Skilled Nursing Facility**
17			**Tarkio Rehab & Health Care Cent**
18			**Shangri-la Rehab & Living Center**
19			**Prairie Rose Care Center**
20			**Illini Heritage Rehab & Health Ce**
21			**Courtyard Estates of Kewanee**
22			**Courtyard Estates of Bradford**
23			**Courtyard Estates of Galva**
24			**Courtyard Estates of Walcott**
25			**Courtyard Village of Kewanee**
26			**Lakewood Village**
27			**Courtyard Estates of Monmouth**
28			**Riverview Estates**
29			**Simple Blessings**
30			**Courtyard Estates of Bushnell**

tions (parties) as defined in the instructions.

JRSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
	City	Name	City	Type of Business
	Toulon			
	Tuscola			
Center	Paris			
nter	Vandalia			
	Watseka			
	West Frankfort			
	Rosiclare			
Center	Mt. Vernon			
Center	Jerseyville			
	Sheldon			
	Tuscola			
	Effingham			
	Collinsville			
r	Osage Beach, MO			
	Gary, IN			
	Poplar Bluff, MO			
er	Tarkio, MO			
	Blue Springs, MO			
	Pana			
nter	Champaign			
	Kewanee			
	Bradford			
	Galva			
	Walcott			
	Kewanee			
	Charleston			
	Monmouth			
	Havana			
	Casey			
	Bushnell			

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Facility Name & ID Number Whispering Oaks

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizat

	1 OWNERS		2 RELATED NU
	Name	**Ownership %**	**Name**
1			Courtyard Estates of Canton
2			Legacy Estates of Monmouth
3			Courtyard Estates of Sullivan
4			Courtyard Estates of Peoria
5			Cornerstone Health and Rehabilita
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tions (parties) as defined in the instructions.

JRSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
	City	Name	City	Type of Business
	Canton			
	Monmouth			
	Sullivan			
	Peoria			
tion	Peoria			

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VII. RELATED PARTIES (continued)

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

NOTE: ALL owners (even those with less than 5% ownership) and their re must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest
1				
2				
3				
4	N/A			
5				
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*** If the owner(s) of this facility or any other related parties listed above have receive of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE A**

**** This must include all forms of compensation paid by related entities and all FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FO ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RES**

Board of Directors.
elatives who receive any type of compensation from this home

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

ed compensation from other nursing homes, attach a schedule detailing the name(s)
AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS

ocated to Schedule V of this report (i.e., management fees).
RMS OF COMPENSATION RECEIVED FROM THIS HOME,
ULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Whispering Oaks #

VIII. ALLOCATION OF INDIRECT COSTS

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	Su All
1	1	Dietary	Resident Days	1,560,986	
2	2	Food	Resident Days	1,560,986	
3	3	Housekeeping	Resident Days	1,560,986	
4	4	Laundry	Resident Days	1,560,986	
5	5	Utilities	Resident Days	1,560,986	
6	6	Maintenance	Resident Days	1,560,986	
7	7	Mgmt. Allocation of Benefits	Resident Days	1,560,986	
8	10	Nursing and Medical Records	Resident Days	1,560,986	
9	10A	Therapy	Resident Days	1,560,986	
10	15	Mgmt. Allocation of Benefits	Resident Days	1,560,986	
11	17	Administrative	Resident Days	1,560,986	
12	19	Professional Services	Resident Days	1,560,986	
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,560,986	
14	21	Clerical and General Office	Resident Days	1,560,986	
15	23	Inservice Training & Education	Resident Days	1,560,986	
16	24	Travel and Seminar	Resident Days	1,560,986	
17	25	Other Admin. Staff Transport.	Resident Days	1,560,986	
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,560,986	
19	27	Mgmt. Allocation of Benefits	Resident Days	1,560,986	
20	30	Depreciation	Resident Days	1,560,986	
21	32	Interest	Resident Days	1,560,986	
22	33	Real Estate Taxes	Resident Days	1,560,986	
23	34	Rent-Facility and Grounds	Resident Days	1,560,986	
24	35	Rent-Equipment & Vehicles	Resident Days	1,560,986	
25	TOTALS				

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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

5 Number of ıbunits Being ocated 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
75	$ 307,592	$ 295,212	4250	$ 837
75	6,577	-	4250	18
75	3,057	-	4250	8
75	-	-	4250	-
75	23,338	-	4250	64
75	150,672	97,358	4250	410
75	17,394	-	4250	47
75	1,082	-	4250	3
75	-	-	4250	-
75	-	-	4250	-
75	4,578,456	4,578,456	4250	35,000
75	648,504	-	4250	1,766
75	41,231	-	4250	112
75	3,812,055	3,383,297	4250	10,379
75	6,148	-	4250	17
75	313	-	4250	1
75	284,745	-	4250	775
75	54,993	-	4250	150
75	352,851	-	4250	961
75	252,711	-	4250	688
75	420,365	-	4250	1,145
75	24,742	-	4250	67
75	-	-	4250	-
75	45,546	-	4250	124
	$ 11,032,372	$ 8,354,323		$ 52,572

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Facility Name & ID Number Whispering Oaks #

VIII. ALLOCATION OF INDIRECT COSTS

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	Su All
1	1	Dietary	Resident Days	200,356	
2	2	Food	Resident Days	200,356	
3	3	Housekeeping	Resident Days	200,356	
4	4	Laundry	Resident Days	200,356	
5	5	Utilities	Resident Days	200,356	
6	6	Maintenance	Resident Days	200,356	
7	7	Mgmt. Allocation of Benefits	Resident Days	200,356	
8	10	Nursing and Medical Records	Resident Days	200,356	
9	12	Therapy	Resident Days	200,356	
10	17	Mgmt. Allocation of Benefits	Resident Days	200,356	
11	19	Administrative	Resident Days	200,356	
12	20	Professional Services	Resident Days	200,356	
13	21	Dues, Fees, Subs & Promotions	Resident Days	200,356	
14	22	Clerical and General Office	Resident Days	200,356	
15	23	Employee Benefits & Payroll	Resident Days	200,356	
16	24	Travel and Seminar	Resident Days	200,356	
17	25	Other Admin. Staff Transport.	Resident Days	200,356	
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	200,356	
19	27	Mgmt. Allocation of Benefits	Resident Days	200,356	
20	30	Depreciation	Resident Days	200,356	
21	32	Interest	Resident Days	200,356	
22	33	Real Estate Taxes	Resident Days	200,356	
23	34	Rent-Facility and Grounds	Resident Days	200,356	
24	35	Rent-Equipment & Vehicles	Resident Days	200,356	
25	TOTALS				

0050625 Report Period Beginning: 1/1/2013 Ending: 2/31/2013

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

5 Number of ıbunits Being ocated 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
12	$ -	$ -	4,250	$ -
12	-	-	4,250	-
12	-	-	4,250	-
12	-	-	4,250	-
12	-	-	4,250	-
12	-	-	4,250	-
12	-	-	4,250	-
12	-	-	4,250	-
12	-	-	4,250	-
12	-	-	4,250	-
12	-	-	4,250	-
12	57,335	-	4,250	1,216
12	1,657	-	4,250	35
12	54,836	-	4,250	1,163
12	(1)	-	4,250	-
12	-	-	4,250	-
12	-	-	4,250	-
12	-	-	4,250	-
12	-	-	4,250	-
12	2,000	-	4,250	42
12	1,219,384	-	4,250	25,866
12	-	-	4,250	-
12	-	-	4,250	-
12	1,832	-	4,250	39
	$ 1,337,043	$		$ 28,361

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Facility Name & ID Number **Whispering Oaks** **#**

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4
	Name of Lender	**Related****		**Purpose of Loan**	**Monthly Payment Required**
		YES	**NO**		
	A. Directly Facility Related				
	Long-Term				
1	**The Private Bank**		**X**	**Mortgage**	**Varies**
2					
3					
4					
5					
	Working Capital				
6					
7					
8					
9	**TOTAL Facility Related**				
	B. Non-Facility Related*				
10					
11					
12					
13					
14	**TOTAL Non-Facility Related**				
15	**TOTALS (line 9+line14)**				

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sc

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, cons (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated (See instructions.)**

necessary.)

5	6		7	8	9	10	
Date of Note	Amount of Note			Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	Original		Balance				
11/1/09	413,015	$	383,485	10/31/2029	Varies	$ 28,297	1
							2
							3
							4
							5
							6
							7
							8
	$ 413,015	$	383,485			$ 28,297	9
							10
							11
			Home Office Allocation-PHC			1,145	12
			Home Office Allocation-PHN			25,866	13
	$	$				$ 27,011	14
	$ 413,015	$	383,485			$ 55,308	15

ch. V. $ _____ Line # _____

equently, page 4, col. 7.

in column 2.

Facility Name & ID Number Whispering Oaks

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report. **Important, please see the next works statement and bill must accompany t**

2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment co

3. Under or (over) accrual (line 2 minus line 1).

4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the li

5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other ge
(Describe appeal cost below. Attach copies of invoices to support the cost and a c

6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.
TOTAL REFUND $ _____ **For** _____ **Tax Year.** **(Attach a copy of the**

7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2008	**4,733**	**8**
	2009	**4,844**	**9**
	2010	**4,964**	**10**
	2011	**4,945**	**11**
	2012	**5,034**	**12**

Accrual based on prior year tax bill.

NOTES:

1. **Please indicate a negative number by use of brackets( ). Dec taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you mu application for real estate tax exemption unless the building** **This denial must be no more than four years old at**

sheet, "RE_Tax". The real estate tax the cost report.		$ 5,100	1
overs more than one year, detail below.)	2012	$ 5,034	2
		$ (66)	3
nes below.)		$ 5,184	4
eneral operating costs on Schedule V, sections A, B or C. copy of the appeal filed with the county.)		$	5
Home Office Allocation real estate tax appeal board's decision.)		67 $	6
		$ 5,185	7

		FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	$		13
14	PLUS APPEAL COST FROM LINE 5	$		14
15	LESS REFUND FROM LINE 6	$		15
16	AMOUNT TO USE FOR RATE CALCULATION	$		16

duct any overaccrual of

ust attach a denial of an
is rented from a for-profit entity.
t the time the cost report is filed.

2012 LONG TERM CARE REAL ESTATE TA

FACILITY NAME Whispering Oaks

FACILITY IDPH LICENSE NUMBER 0050625

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

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

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

Enter the tax index number and real estate tax assessed for 2012 on the lines provi
cost that applies to the operation of the nursing home in Column D. Real estate ta
home property which is vacant, rented to other organizations, or used for purposes
entered in Column D. Do not include cost for any period other than calendar year

	(A) Tax Index Number	(B) Property Description	
1.	06-82-057-08-000	Long-Term Care Facility	$
2.			$
3.			$
4.			$
5.			$
6.			$
7.			$
8.			$
9.			$
10.			$
		TOTALS	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant prop
used for nursing home services? _____ YES _____ NO

If YES, attach an explanation and a schedule which shows the calculation of the c
(Generally the real estate tax cost must be allocated to the nursing home based upc

C. **Tax Bills**

Attach a copy of the original 2012 tax bills which were listed in Section A to this s
tax bill which is normally paid during 2013.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is
documentation . Facilities located in Cook County are required to provide
installment tax bill.

X STATEMENT

COUNTY Hardin

-8622

ded below. Enter only the portion of the
x applicable to any portion of the nursing
; other than long term care must not be
2012.

(C) Total Tax	(D) Tax Applicable to Nursing Home
5,033.86	$ 5,033.86
	$
	$
	$
	$
	$
	$
	$
	$
	$
5,033.86	$ 5,033.86

erty, or property which is not directly

ost allocated to the nursing home.
on sq. ft. of space used.)

statement. Be sure to use the 2012

not considered acceptable tax bill
copies of their original **second**

Facility Name & ID Number Whispering Oaks

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 3,320 **B. General Construction Type:** Exterior

C. Does the Operating Entity? [X] **(a) Own the Facility** [ ] **(b) Rent from a**

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedul

D. Does the Operating Entity? [X] **(a) Own the Equipment** [ ] **(b) Rent equipr**

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Sched

E. List all other business entities owned by this operating entity or related to the operating entity that a (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, ind List entity name, type of business, square footage, and number of beds/units available (where applic

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? If so, please complete the following:

1. Total Amount Incurred: 2,058

3. Current Period Amortization: 2,058

Nature of Costs:

(Attach a complete schedule detailing the total amount o

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet
1	Facility	10,000
2		
3	TOTALS	10,000

Vinyl Siding Frame Wood Number of Stories 1

ı Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

e XI or Schedule XII-A. See instructions.)

nent from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.

lule XI-C or Schedule XII-B. See instructions.)

ıre located on or adjacent to this nursing home's grounds
ependent living facilities, CNA training facilities, etc.)
able).

☒ YES ☐ NO

2. Number of Years Over Which it is Being Amortized: 1

4. Dates Incurred: 2013-Loan Costs for Failed Loan Application

f organization and pre-operating costs.)

	3 Year Acquired	4 Cost	
	2006	$ 10,000	1
			2
		$ 10,000	3

Facility Name & ID Number **Whispering Oaks**

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.)

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	
4	16		2006	1994	$
5					
6					
7					
8					
	Improvement Type**				
9	A/C Unit			2009	
10	A/C Unit			2010	
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					
21					
22					
23					
24					
25					
26					
27					
28					
29					
30					
31	Building Booked				
32	Building Improvement Booked				
33					
34	2013-Home Office Allocation-Building Improvements				
35	2013-Home Office Allocation-Land Improvements				
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.**

STATE OF ILLINOIS

 # 0050625 Report Period Beginning: 1/1/2013 Ending:

Round all numbers to nearest dollar.

4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	Ac De
530,000	$	25	$ 21,200	$ 21,200	$
2,985		5	598	598	
3,860		15	258	258	
	21,200			(21,200)	
	855			(855)	
1,998			48	48	
187			12	12	

See Page 12A, Line 70 for total

9 ccumulated epreciation	
158,842	4
	5
	6
	7
	8
2,691	9
903	10
	11
	12
	13
	14
	15
	16
	17
	18
	19
	20
	21
	22
	23
	24
	25
	26
	27
	28
	29
	30
	31
	32
	33
	34
	35
	36

Facility Name & ID Number Whispering Oaks

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.)

	1 Improvement Type**	3 Year Constructed	
37			$
38			
39			
40			
41			
42			
43			
44			
45			
46			
47			
48			
49			
50			
51			
52			
53			
54			
55			
56			
57			
58			
59			
60			
61			
62			
63			
64			
65			
66			
67			
68			
69			
70	TOTAL (lines 4 thru 69)		$

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

STATE OF ILLINOIS

\# 0050625 Report Period Beginning: 1/1/2013 Ending:

Round all numbers to nearest dollar.

4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	Ac De
	$		$	$	$
539,030	$ 22,055		$ 22,116	$ 61	$

9 ccumulated epreciation	
	37
	38
	39
	40
	41
	42
	43
	44
	45
	46
	47
	48
	49
	50
	51
	52
	53
	54
	55
	56
	57
	58
	59
	60
	61
	62
	63
	64
	65
	66
	67
	68
	69
162,436	70

Facility Name & ID Number Whispering Oaks # 0050625

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	
71	Purchased in Prior Years	$ 69,605	$
72	Current Year Purchases		
73	Fully Depreciated Assets		
74	Home Office Allocation		
75	TOTALS	$ 69,605	$

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost
76				$
77				
78				
79				
80	TOTALS			$

E. Summary of Care-Related Assets

		Re
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thr
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thr
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thr
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thr

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		$	$	$
87	N/A			
88				
89				
90				
91	TOTALS	$	$	$

Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
585	$ 5,041	$ 4,456	5-10 yrs.	$ 67,390	71
					72
					73
	670	670			74
585	$ 5,711	$ 5,126		$ 67,390	75

Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
$	$	$		$	76
					77
					78
					79
$	$	$		$	80

1 eference	2 Amount		
(Pages 12B thru 12I, if applicable)	$ 618,635	81	
ru 12I, if applicable)	$ 22,640	82	
ru 12I, if applicable)	$ 27,827	83	**
ru 12I, if applicable)	$ 5,187	84	
ru 12I, if applicable)	$ 229,826	85	

G. Construction-in-Progress

		Description	Cost	
86	92		$	92
87	93	N/A		93
88	94			94
89	95		$	95
90				
91				

* 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.

STA

Facility Name & ID Number Whispering Oaks #

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, c
   If NO, see instructions. ☐

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount
3	Original Building:				$
4	Additions				
5					
6					
7	TOTAL				$

**

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

9. Option to Buy: ☐ YES ☐ NO Terms:

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

15. Is Movable equipment rental included in building rental? ☐
16. Rental Amount for movable equipment: $ 6,348 Description: See A

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	
17			$	$
18				
19				
20				
21	TOTAL		$	$

column 4?
YES ☐ NO

5 Total Years of Lease	6 Total Years Renewal Option*	
		3
		4
		5
		6
		7

*

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.	/2014	$
13.	/2015	$
14.	/2016	$

YES ☒ NO
ttached Schedule 14A
(Attach a schedule detailing the breakdown of movable equipment)

4 Rental Expense for this Period	
	17
	18
	19
	20
	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.

Whispering Oaks
0050625
Period Beginning **1/1/2013**
Period End **12/31/2013**

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	$	5,466
Dishwasher		-
Maintenace Equipment		30
Copier		689
Home Office Allocation		163
		6,348

Facility Name & ID Number Whispering Oaks

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

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a sch

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

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

2. CLASSROOM PO
IN-HOUSE PROG
IN OTHER FACII
COMMUNITY CC
HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS

			1	2	
			Facility		
			Drop-outs	Completed	
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)	$		

(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.

tructions.)

edule listing the facility name, address and cost per CNA trained in that facility.)

RTION:		3. CLINICAL PORTION:	
RAM		IN-HOUSE PROGRAM	
LITY		IN OTHER FACILITY	
OLLEGE		HOURS PER CNA	

(d)

3	4
Contract	Total
	$
	$

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	

(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 **Whispering Oaks**

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

		1	2	
	Service	Schedule V Line & Column Reference	Staff Units of Service	
1	Licensed Occupational Therapist		hrs	$
2	Licensed Speech and Language Development Therapist		hrs	
3	Licensed Recreational Therapist		hrs	
4	Licensed Physical Therapist		hrs	
5	Physician Care		visits	
6	Dental Care		visits	
7	Work Related Program	N/A	hrs	
8	Habilitation		hrs	
9	Pharmacy		# of prescrpts	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs	
11	Academic Education		hrs	
12	Other (specify):			
13	Other (specify):			
14	TOTAL			$

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitio
Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with tl
on this schedule.

STATE OF ILLINOIS
 # 0050625 Report Period Beginning: 1/1/2013 Ending:

3	4	5	6	7	
Cost	Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	To (Col.
	Units	Cost			
		$	$		$
		$	$		$

ners. Consultant fees should be detailed on
he above activities should not be listed

8	
tal Cost . 3 + 5 + 6)	
	1
	2
	3
	4
	5
	6
	7
	8
	9
	10
	11
	12
	13
	14

Facility Name & ID Number Whispering Oaks **STATE #**

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of**

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	$ 847,847	$ 847,847	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 918)	57,777	57,777	3
4	Supply Inventory (priced at)	1,616	1,616	4
5	Short-Term Investments			5
6	Prepaid Insurance	6,491	6,491	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Security Deposit	285	285	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 914,016	$ 914,016	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	10,000	10,000	13
14	Buildings, at Historical Cost	530,000	531,998	14
15	Leasehold Improvements, at Historical Cost	6,845	7,032	15
16	Equipment, at Historical Cost	69,605	69,605	16
17	Accumulated Depreciation (book methods)	(233,036)	(229,826)	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): A/R Prior Owner	2,150	2,150	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 385,564	$ 390,959	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,299,580	$ 1,304,975	25

***(See in**

0050625 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

12/31/2013 (last day of reporting year)

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 361,948	$ 361,948	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	11,130	11,130	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,507	1,507	31
32	Accrued Real Estate Taxes(Sch.IX-B)	5,184	5,184	32
33	Accrued Interest Payable	2,383	2,383	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	**Payroll Withholdings**	2,961	2,961	36
37	**Accrued Management Fees**	47,695	47,695	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 432,808	$ 432,808	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	383,485	383,485	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	**Due To/Due From**	48,011	48,011	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 431,496	$ 431,496	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 864,304	$ 864,304	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 435,276	$ 440,671	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,299,580	$ 1,304,975	48

ıstructions.)

Facility Name & ID Number Whispering Oaks #

XVI. STATEMENT OF CHANGES IN EQUITY

1	**Balance at Beginning of Year, as Previously Reported**	**$**
2	Restatements (describe):	
3	**Rounding**	
4		
5		
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	**$**
	A. Additions (deductions):	
7	NET Income (Loss) (from page 19, line 43)	
8	Aquisitions of Pooled Companies	
9	Proceeds from Sale of Stock	
10	Stock Options Exercised	
11	Contributions and Grants	
12	Expenditures for Specific Purposes	
13	Dividends Paid or Other Distributions to Owners	**(**
14	Donated Property, Plant, and Equipment	
15	Other (describe)	
16	Other (describe)	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	**$**
	B. Transfers (Itemize):	
18		
19		
20		
21		
22		
23	**TOTAL Transfers (sum of lines 18-22)**	**$**
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	**$**

1 Total		
490,837	1	
	2	
1	3	
	4	
	5	
490,838	6	
(55,562)	7	
	8	
	9	
	10	
	11	
	12	
)	13	
	14	
	15	
	16	
(55,562)	17	
	18	
	19	
	20	
	21	
	22	
	23	
435,276	24	*

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

STATE OF ILLINOI

Facility Name & ID Number Whispering Oaks # 0050625

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this sched
classifications of revenue and expense must be provided on this form, even if financial statem
Note: This schedule should show gross revenue and expenses. Do not net revenue

	I. Revenue	1 Amount		
	A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	$ 438,889	1	31
2	Discounts and Allowances for all Levels	( )	2	32
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 438,889	3	33
	B. Ancillary Revenue			
4	Day Care		4	34
5	Other Care for Outpatients		5	
6	Therapy		6	35
7	Oxygen		7	36
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8	
	C. Other Operating Revenue			37
9	Payments for Education		9	38
10	Other Government Grants		10	39
11	CNA Training Reimbursements		11	
12	Gift and Coffee Shop		12	40
13	Barber and Beauty Care		13	
14	Non-Patient Meals	291	14	41
15	Telephone, Television and Radio		15	
16	Rental of Facility Space		16	42
17	Sale of Drugs		17	
18	Sale of Supplies to Non-Patients		18	43
19	Laboratory		19	
20	Radiology and X-Ray		20	
21	Other Medical Services		21	44
22	Laundry		22	45
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 291	23	46
	D. Non-Operating Revenue			47
24	Contributions		24	48
25	Interest and Other Investment Income***		25	49
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26	
	E. Other Revenue (specify):**			*
27	Settlement Income (Insurance, Legal, Etc.)		27	**
28	Transportation Revenue	4,681	28	
28a			28a	***
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,681	29	
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 443,861	30	****]

Report Period Beginning: 1/1/2013 **Ending:** 12/31/2013

ule to Schedules V and VI.) All required
ents are attached.
e against expense.

II. Expenses	2 Amount	
A. Operating Expenses		
General Services	69,691	31
Health Care	189,286	32
General Administration	136,595	33
B. Capital Expense		
Ownership	64,298	34
C. Ancillary Expense		
Special Cost Centers	9,941	35
Provider Participation Fee	29,612	36
D. Other Expenses (specify):		
		37
		38
		39
TOTAL EXPENSES (sum of lines 31 thru 39)*	$ 499,423	40
Income before Income Taxes (line 30 minus line 40)**	(55,562)	41
Income Taxes		42
NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	$ (55,562)	43

III. Net Inpatient Revenue detailed by Payer Source		
Medicaid - Net Inpatient Revenue	$ 438,889	44
Private Pay - Net Inpatient Revenue		45
Medicare - Net Inpatient Revenue		46
Other-(specify)		47
Other-(specify)		48
TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 438,889	49

This must agree with page 4, line 45, column 4.
Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.
See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

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

Facility Name & ID Number Whispering Oaks #

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

		1	2**	3	4
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
1	Director of Nursing			$	$
2	Assistant Director of Nursing				
3	Registered Nurses				
4	Licensed Practical Nurses				
5	CNAs & Orderlies	15,908	16,592	141,390	8.52
6	CNA Trainees				
7	Licensed Therapist				
8	Rehab/Therapy Aides				
9	Activity Director				
10	Activity Assistants				
11	Social Service Workers	2,057	2,192	22,617	10.32
12	Dietician				
13	Food Service Supervisor				
14	Head Cook				
15	Cook Helpers/Assistants	2,757	2,954	25,497	8.63
16	Dishwashers				
17	Maintenance Workers				
18	Housekeepers				
19	Laundry				
20	Administrator	2,080	2,080	35,000	16.83
21	Assistant Administrator				
22	Other Administrative				
23	Office Manager				
24	Clerical				
25	Vocational Instruction				
26	Academic Instruction				
27	Medical Director				
28	Qualified MR Prof. (QMRP)				
29	Resident Services Coordinator				
30	Habilitation Aides (DD Homes)				
31	Medical Records				
32	Other Health Care(specify)				
33	Other(specify) Daily Living Aides	697	857	7,625	8.90
34	TOTAL (lines 1 - 33)	23,499	24,675	$ 232,129 *	$ 9.41

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

** See instructions.

B. CONSULTANT SERVICES

			1	2	3
			Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference
1					
2	35	Dietary Consultant	23	$ 1,166	L1, C3
3	36	Medical Director	Monthly	3,600	L9, C3
4	37	Medical Records Consultant			
5	38	Nurse Consultant	31	1,565	L10, C3
6	39	Pharmacist Consultant	Monthly	949	L10, C3
7	40	Physical Therapy Consultant			
8	41	Occupational Therapy Consultant			
9	42	Respiratory Therapy Consultant			
10	43	Speech Therapy Consultant			
11	44	Activity Consultant			
12	45	Social Service Consultant			
13	46	Other(specify)			
14	47				
15	48				
16					
17	49	TOTAL (lines 35 - 48)	54	$ 7,280	
18					
19					
20					

C. CONTRACT NURSES

			1	2	3
			Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference
21					
22					
23	50	Registered Nurses		$	
24	51	Licensed Practical Nurses	N/A		
25	52	Certified Nurse Assistants/Aides			
26					
27	53	TOTAL (lines 50 - 52)		$	
28					
29					
30					
31					
32					
33					
34					


35
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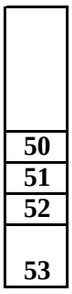
50
51
52
53

Facility Name & ID Number Whispering Oaks

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jessica Hershey	Administrator	0	$ 35,000
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 35,000

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 63,200
TOTAL (agree to Schedule V, line 17, col. 3)	$ 63,200
(Attach a copy of any management service agreement)	

7

C. Professional Services

Vendor/Payee	Type	Amount
Shawnee Communications	Computer Services	$ 389
Michigan Peer Review	Consulting Fees	2,510
E-Health Data Services	Computer Services	2,025
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 4,924

STATE OF ILLINOIS

0050625 Report Period Beginning: 1/1/2013

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 6,929
Unemployment Compensation Insurance	8,092
FICA Taxes	15,634
Employee Health Insurance	7,815
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	12,039
TOTAL (agree to Schedule V, line 22, col.8)	$ 50,509

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

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and P

Description
IDPH License Fee
Advertising: Employee Recruitme
Health Care Worker Background
(Indicate # of checks performed
Patient Background Checks
Miscellaneous Licenses & Permits
Miscellaneous Dues & Subscriptio
Home Office Allocation
Less: Public Relations Expense
Non-allowable advertising
Yellow page advertising
TOTAL (agree to Sch. line 20, col. 8)

G. Schedule of Travel and Semina

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

* Attach copy of IMRF notifications

**See instructions.

romotions

		Amount
	$	
nt		
Check		
)		
11		112
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ıs		0
		147
	(	)
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V,	$	259

r**

		Amount
	$	
		1
	(	)
	$	1

Whispering Oaks
0050625
Period Beginning **1/1/2013**
Period End **12/31/2013**

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	**Type**	**Amount**
Total (agree to Schedule V, line 19, column 3)		4,924
Home Office Allocation		
SmithAmundsen	Legal	105
Cole, Schotz, Meisel	Legal	138
Black, Hedin, Ballard	Legal	5
Ginoli & Company	Accountants	191
RSM McGladrey	Accountants	484
Miscellaneous	Computer Services	16
Odessian LLC	Computer Services	8
CCH	Computer Services	2
Lexis-Nexis	Computer Services	1
Ipanema Solutions	Computer Services	2
Macquarie Technology Services	Computer Services	15
Advanced Answers on Demand	Computer Services	777
TeamViewer	Computer Services	3
Stratus Networks	Computer Services	63
Kemper Technology	Computer Services	48
AT&T	Computer Services	1
Medifax	Computer Services	7
Vision Share/Ability Network	Computer Services	106
Barracuda	Computer Services	19
CIAN	Computer Services	26
Comcast	Computer Services	6
Emdeon	Computer Services	9
Marotta Gund Budd & Dzera	Other Prof Fees	238
David Budde	Other Prof Fees	5
Pharmacy Price Mangement	Other Prof Fees	20
All Scripts	Other Prof Fees	581
Red Ridge Financial Group	Other Prof Fees	106
Total (agree to Schedule V, line 19, column 8)		7,906

STATE OF IL

Facility Name & ID Number Whispering Oaks #

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in S

(See instructions.)

	1	2	3	4	5	6	
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	
1			$		$	$	$
2							
3							
4	N/A						
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20	TOTALS		$		$	$	$

ch. V, line 6, col. 3).

7	8	9	10	11	12	13
	Amount of Expense Amortized Per Year					
FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
	$	$	$	$	$	$
	$	$	$	$	$	$

Facility Name & ID Number **Whispering Oaks**

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. $ **2,220** 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. $ **29,612**
This amount is to be recorded on line 42 of Schedule V.

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

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

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **291**

(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. $ **4,681**

c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**

d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**

e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**

g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

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

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

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **No**
Attach invoices and a summary of services for all architect and appraisal fees.