		FOR BHF USE					

LL1

2009
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2009)

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: 0049213

Facility Name: Flanagan Rehabilitation & Health Care Center

Address: 201 East Falcon Highway (Number) Flanagan (City) 61740 (Zip Code)

County: Livingston

Telephone Number: 815-796-2267 **Fax #** 815-796-4434

HFS ID Number: 201032291014

Date of Initial License for Current Owners: 11/1/2007

Type of Ownership:

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2009 to 12/31/2009 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 # ( )

In the event there are further questions about this report, please contact:
Name: Larry Templin Telephone Number: (309) 691-8113
Email Address:

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 Flanagan Rehabilitation & Health Care Center # 0049213 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	43	Skilled (SNF)	43	15,695	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	32	Sheltered Care (SC)	32	11,680	5
6		ICF/DD 16 or Less			6
7	75	TOTALS	75	27,375	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	6,953	2,336	1,700	10,989	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		2,444		2,444	12
13	DD 16 OR LESS					13
14	TOTALS	6,953	4,780	1,700	13,433	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 49.07%

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 11/1/2007

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/1/2007 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 43 and days of care provided 1,430

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: 12/31/2009 Fiscal Year: 12/31/2009

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

Facility Name & ID Number Flanagan Rehabilitation & Health Care Cent # 0049213 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

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	145,628	9,466		155,094		155,094	2,349	157,443			1
2	Food Purchase		79,217		79,217		79,217	(2,596)	76,621			2
3	Housekeeping	60,445	15,019		75,464		75,464	22	75,486			3
4	Laundry	29,784	5,283		35,067		35,067		35,067			4
5	Heat and Other Utilities			78,536	78,536		78,536	232	78,768			5
6	Maintenance	34,401	4,810	19,696	58,907		58,907	1,138	60,045			6
7	Other (specify):* Home Off. Ben. All.							424	424			7
8	TOTAL General Services	270,258	113,795	98,232	482,285		482,285	1,569	483,854			8
	B. Health Care and Programs											
9	Medical Director			4,800	4,800		4,800		4,800			9
10	Nursing and Medical Records	758,359	39,677	5,138	803,174		803,174	(86)	803,088			10
10a	Therapy		25	211,345	211,370		211,370		211,370			10a
11	Activities	37,467	271	353	38,091		38,091	(60)	38,031			11
12	Social Services	23,121			23,121		23,121		23,121			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Off. Ben. All.							175	175			15
16	TOTAL Health Care and Programs	818,947	39,973	221,636	1,080,556		1,080,556	29	1,080,585			16
	C. General Administration											
17	Administrative	14,747		86,800	101,547		101,547	(40,222)	61,325			17
18	Directors Fees											18
19	Professional Services			10,313	10,313		10,313	4,502	14,815			19
20	Dues, Fees, Subscriptions & Promotions			3,267	3,267		3,267	949	4,216			20
21	Clerical & General Office Expenses	25,600	3,709	11,023	40,332		40,332	26,727	67,059			21
22	Employee Benefits & Payroll Taxes			173,653	173,653		173,653	4,212	177,865			22
23	Inservice Training & Education							245	245			23
24	Travel and Seminar							75	75			24
25	Other Admin. Staff Transportation			11,514	11,514		11,514	1,180	12,694			25
26	Insurance-Prop.Liab.Malpractice			26,979	26,979		26,979	490	27,469			26
27	Other (specify):* Home Off. Ben. All.							6,430	6,430			27
28	TOTAL General Administration	40,347	3,709	323,549	367,605		367,605	4,588	372,193			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,129,552	157,477	643,417	1,930,446		1,930,446	6,186	1,936,632			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 Flanagan Rehabilitation & Health Care Center #0049213 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			55,685	55,685		55,685	(4,537)	51,148			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			65,223	65,223		65,223	8,449	73,672			32
33	Real Estate Taxes			24,374	24,374		24,374	297	24,671			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			10,879	10,879		10,879	285	11,164			35
36	Other (specify):*											36
37	TOTAL Ownership			156,161	156,161		156,161	4,494	160,655			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		50,554		50,554		50,554		50,554			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			23,543	23,543		23,543		23,543			42
43	Other (specify):* Non-allowable Cost	35,108	1,568	141,223	177,899		177,899	(177,899)				43
44	TOTAL Special Cost Centers	35,108	52,122	164,766	251,996		251,996	(177,899)	74,097			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,164,660	209,599	964,344	2,338,603		2,338,603	(167,219)	2,171,384			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 Flanagan Rehabilitation & Health Care Center # 0049213 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

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	(1,538)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,173)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(6,785)	30		9
10	Interest and Other Investment Income	(4,183)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(79)	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	(454)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(119,547)	43		24
25	Fund Raising, Advertising and Promotional	(39,936)	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 Pg. 5A	(14,725)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (193,420)		$	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)	26,201	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 26,201		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (167,219)		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					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Flanagan Rehabilitation & Health Care Center

ID# 0049213

Report Period Beginning: 1/1/2009

Ending: 12/31/2009

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs-Part A	$ (9,799)	43	1
2	X-Rays-Part A	(144)	43	2
3	Offset Nursing Supplies Revenue	(1,508)	10	3
4	Offset Miscellaneous Vending Revenue	(1,111)	2	4
5	Offset Miscellaneous Office Supplies Revenue	(86)	21	5
6	Offset Transortation Revenue	(60)	11	6
7	Disallowed Special Events	(551)	43	7
8	Pet Expense	(1,216)	43	8
9	Disallw Chamber of Commerce Dues	(250)	20	9
10				10
11				11
12				12
13				13
14				14
15				15
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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**	(14,725)		49

Facility Name & ID Number Flanagan Rehabilitation & Health Care Center # 0049213 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark Petersen	100	See Attached Schedule 6E		See Attached Sch 6E		

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%	$ 2,349	$ 2,349	1
2	V	2	Food		Petersen Health Care, Inc.	100.00%	53	53	2
3	V	3	Housekeeping		Petersen Health Care, Inc.	100.00%	22	22	3
4	V	4	Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5	Utilities		Petersen Health Care, Inc.	100.00%	232	232	5
6	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	1,138	1,138	6
7	V	7	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	424	424	7
8	V	10	Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	1,422	1,422	8
9	V	11	Activities		Petersen Health Care, Inc.	100.00%	0		9
10	V	15	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	175	175	10
11	V	17	Administrative	86,800	Petersen Health Care, Inc.	100.00%	46,578	(40,222)	11
12	V	19	Professional Services		Petersen Health Care, Inc.	100.00%	3,294	3,294	12
13	V								13
14	Total			$ 86,800			$ 55,687	$ * (31,113)	14

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

Facility Name & ID Number Flanagan Rehabilitation & Health Care Center # 0049213 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	20	Dues, Fees, Subs and Promotions	$	Petersen Health Care, Inc.	100.00%	$ 918	$ 918	15
16	V	21	Clerical and General Office		Petersen Health Care, Inc.	100.00%	23,954	23,954	16
17	V	23	Inservice Training and Education		Petersen Health Care, Inc.	100.00%	245	245	17
18	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	75	75	18
19	V	25	Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	1,180	1,180	19
20	V	26	Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	490	490	20
21	V	27	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	6,430	6,430	21
22	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	1,936	1,936	22
23	V	32	Interest		Petersen Health Care, Inc.	100.00%	2,978	2,978	23
24	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	297	297	24
25	V	34	Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0		25
26	V	35	Rent-Equipment and Vehicles		Petersen Health Care, Inc.	100.00%	285	285	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			$			$ 38,788	$ * 38,788	39

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

Facility Name & ID Number Flanagan Rehabilitation & Health Care Center # 0049213 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Petersen Companies, LLC	100.00%	$ 0	$	15
16	V	2	Food		Petersen Companies, LLC	100.00%	0		16
17	V	3	Housekeeping		Petersen Companies, LLC	100.00%	0		17
18	V	4	Laundry		Petersen Companies, LLC	100.00%	0		18
19	V	5	Utilities		Petersen Companies, LLC	100.00%	0		19
20	V	6	Maintenance		Petersen Companies, LLC	100.00%	0		20
21	V	7	Mgmt. Allocation of Benefits		Petersen Companies, LLC	100.00%	0		21
22	V	10	Nursing and Medical Records		Petersen Companies, LLC	100.00%	0		22
23	V	10A	Therapy		Petersen Companies, LLC	100.00%	0		23
24	V	15	Mgmt. Allocation of Benefits		Petersen Companies, LLC	100.00%	0		24
25	V	17	Administrative		Petersen Companies, LLC	100.00%	0		25
26	V	19	Professional Services		Petersen Companies, LLC	100.00%	1,208	1,208	26
27	V	20	Dues, Fees, Subs & Promotions		Petersen Companies, LLC	100.00%	281	281	27
28	V	21	Clerical and General Office		Petersen Companies, LLC	100.00%	2,859	2,859	28
29	V	22	Employee Benefits & Payroll		Petersen Companies, LLC	100.00%	4,212	4,212	29
30	V	24	Travel and Seminar		Petersen Companies, LLC	100.00%	0		30
31	V	25	Other Admin. Staff Transport.		Petersen Companies, LLC	100.00%	0		31
32	V	26	Insurance-Prop./Liab./Malprac.		Petersen Companies, LLC	100.00%	0		32
33	V	27	Mgmt. Allocation of Benefits		Petersen Companies, LLC	100.00%	0		33
34	V	30	Depreciation		Petersen Companies, LLC	100.00%	312	312	34
35	V	32	Interest		Petersen Companies, LLC	100.00%	5,709	5,709	35
36	V	33	Real Estate Taxes		Petersen Companies, LLC	100.00%	0		36
37	V	34	Rent-Facility and Grounds		Petersen Companies, LLC	100.00%	0		37
38	V	35	Rent-Equipment & Vehicles		Petersen Companies, LLC	100.00%	0		38
39	Total			$			$ 14,581	$ * 14,581	39

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

Facility Name & ID Number Flanagan Rehabilitation & Health Care Center # 0049213 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Petersen Health Network, LLC	100.00%	$	$	15
16	V	2	Food		Petersen Health Network, LLC	100.00%			16
17	V	3	Housekeeping		Petersen Health Network, LLC	100.00%			17
18	V	4	Laundry		Petersen Health Network, LLC	100.00%			18
19	V	5	Utilities		Petersen Health Network, LLC	100.00%			19
20	V	6	Maintenance		Petersen Health Network, LLC	100.00%			20
21	V	7	Mgmt. Allocation of Benefits		Petersen Health Network, LLC	100.00%			21
22	V	10	Nursing and Medical Records		Petersen Health Network, LLC	100.00%			22
23	V	10A	Therapy		Petersen Health Network, LLC	100.00%			23
24	V	15	Mgmt. Allocation of Benefits		Petersen Health Network, LLC	100.00%			24
25	V	17	Administrative		Petersen Health Network, LLC	100.00%			25
26	V	19	Professional Services		Petersen Health Network, LLC	100.00%			26
27	V	20	Dues, Fees, Subs & Promotions		Petersen Health Network, LLC	100.00%			27
28	V	21	Clerical and General Office		Petersen Health Network, LLC	100.00%			28
29	V	23	Inservice Training & Education		Petersen Health Network, LLC	100.00%			29
30	V	24	Travel and Seminar		Petersen Health Network, LLC	100.00%			30
31	V	25	Other Admin. Staff Transport.		Petersen Health Network, LLC	100.00%			31
32	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Network, LLC	100.00%			32
33	V	27	Mgmt. Allocation of Benefits		Petersen Health Network, LLC	100.00%			33
34	V	30	Depreciation		Petersen Health Network, LLC	100.00%			34
35	V	32	Interest		Petersen Health Network, LLC	100.00%	3,945	3,945	35
36	V	33	Real Estate Taxes		Petersen Health Network, LLC	100.00%			36
37	V	34	Rent-Facility and Grounds		Petersen Health Network, LLC	100.00%			37
38	V	35	Rent-Equipment & Vehicles		Petersen Health Network, LLC	100.00%			38
39	Total			$			$ 3,945	$ * 3,945	39

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

Facility Name & ID Number Flanagan Rehabilitation & Health Care Cen # 0049213 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

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	Mark Petersen	President	Administrative	100.00	157,586	0.52	0.87	Salary	$ 1,527	L17, C7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 1,527		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 Flanagan Rehabilitation & Health Care Center # 0049213 Report Period Beginning: 1/1/2009 Ending: 2/31/2009

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	1,493,044	75	$ 261,102	$ 259,584	13,433	$ 2,349	1
2	2	Food	Resident Days	1,493,044	75	5,864	0	13,433	53	2
3	3	Housekeeping	Resident Days	1,493,044	75	2,458	0	13,433	22	3
4	4	Laundry	Resident Days	1,493,044	75	0	0	13,433	0	4
5	5	Utilities	Resident Days	1,493,044	75	25,776	0	13,433	232	5
6	6	Maintenance	Resident Days	1,493,044	75	126,463	107,810	13,433	1,138	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	47,148	0	13,433	424	7
8	10	Nursing and Medical Records	Resident Days	1,493,044	75	158,020	151,697	13,433	1,422	8
9	10A	Therapy	Resident Days	1,493,044	75	0	0	13,433	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	19,462	0	13,433	175	10
11	17	Administrative	Resident Days	1,493,044	75	3,315,953	3,315,953	13,433	46,578	11
12	19	Professional Services	Resident Days	1,493,044	75	366,089	0	13,433	3,294	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,493,044	75	102,022	0	13,433	918	13
14	21	Clerical and General Office	Resident Days	1,493,044	75	2,662,394	2,253,243	13,433	23,954	14
15	23	Inservice Training & Education	Resident Days	1,493,044	75	27,176	0	13,433	245	15
16	24	Travel and Seminar	Resident Days	1,493,044	75	8,381	0	13,433	75	16
17	25	Other Admin. Staff Transport.	Resident Days	1,493,044	75	131,200	0	13,433	1,180	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,493,044	75	54,425	0	13,433	490	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	714,650	0	13,433	6,430	19
20	30	Depreciation	Resident Days	1,493,044	75	215,197	0	13,433	1,936	20
21	32	Interest	Resident Days	1,493,044	75	330,981	0	13,433	2,978	21
22	33	Real Estate Taxes	Resident Days	1,493,044	75	33,065	0	13,433	297	22
23	34	Rent-Facility and Grounds	Resident Days	1,493,044	75	0	0	13,433	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,493,044	75	31,635	0	13,433	285	24
25	TOTALS					$ 8,639,461	$ 6,088,287		$ 94,475	25

Facility Name & ID Number Flanagan Rehabilitation & Health Care Center # 0049213 Report Period Beginning: 1/1/2009 Ending: 2/31/2009

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 Companies, LLC
Street Address: 830 W. Trailcreek Drive
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 691-8113
Fax Number: (309) 691-8622

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	198,749	13	$	$	11,164	$	1
2	2	Food	Resident Days	198,749	13			11,164		2
3	3	Housekeeping	Resident Days	198,749	13			11,164		3
4	4	Laundry	Resident Days	198,749	13			11,164		4
5	5	Utilities	Resident Days	198,749	13			11,164		5
6	6	Maintenance	Resident Days	198,749	13			11,164		6
7	7	Mgmt. Allocation of Benefits	Resident Days	198,749	13			11,164		7
8	10	Nursing and Medical Records	Resident Days	198,749	13			11,164		8
9	10A	Therapy	Resident Days	198,749	13			11,164		9
10	15	Mgmt. Allocation of Benefits	Resident Days	198,749	13			11,164		10
11	17	Administrative	Resident Days	198,749	13			11,164		11
12	19	Professional Services	Resident Days	198,749	13	21,502		11,164	1,208	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	198,749	13	4,999		11,164	281	13
14	21	Clerical and General Office	Resident Days	198,749	13	50,893		11,164	2,859	14
15	22	Employee Benefits & Payroll	Resident Days	198,749	13	74,975		11,164	4,212	15
16	24	Travel and Seminar	Resident Days	198,749	13			11,164		16
17	25	Other Admin. Staff Transport.	Resident Days	198,749	13			11,164		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	198,749	13			11,164		18
19	27	Mgmt. Allocation of Benefits	Resident Days	198,749	13			11,164		19
20	30	Depreciation	Resident Days	198,749	13	5,550		11,164	312	20
21	32	Interest	Resident Days	198,749	13	101,632		11,164	5,709	21
22	33	Real Estate Taxes	Resident Days	198,749	13			11,164		22
23	34	Rent-Facility and Grounds	Resident Days	198,749	13			11,164		23
24	35	Rent-Equipment & Vehicles	Resident Days	198,749	13			11,164		24
25	TOTALS					$ 259,551	$		$ 14,581	25

Facility Name & ID Number Flanagan Rehabilitation & Health Care Center # 0049213 Report Period Beginning: 1/1/2009 Ending: 2/31/2009

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 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

	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	32,882	12	$	$	2,269	$	1
2	2	Food	Resident Days	32,882	12			2,269		2
3	3	Housekeeping	Resident Days	32,882	12			2,269		3
4	4	Laundry	Resident Days	32,882	12			2,269		4
5	5	Utilities	Resident Days	32,882	12			2,269		5
6	6	Maintenance	Resident Days	32,882	12			2,269		6
7	7	Mgmt. Allocation of Benefits	Resident Days	32,882	12			2,269		7
8	10	Nursing and Medical Records	Resident Days	32,882	12			2,269		8
9	10A	Therapy	Resident Days	32,882	12			2,269		9
10	15	Mgmt. Allocation of Benefits	Resident Days	32,882	12			2,269		10
11	17	Administrative	Resident Days	32,882	12			2,269		11
12	19	Professional Services	Resident Days	32,882	12			2,269		12
13	20	Dues, Fees, Subs & Promotions	Resident Days	32,882	12			2,269		13
14	21	Clerical and General Office	Resident Days	32,882	12			2,269		14
15	23	Inservice Training & Education	Resident Days	32,882	12			2,269		15
16	24	Travel and Seminar	Resident Days	32,882	12			2,269		16
17	25	Other Admin. Staff Transport.	Resident Days	32,882	12			2,269		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	32,882	12			2,269		18
19	27	Mgmt. Allocation of Benefits	Resident Days	32,882	12			2,269		19
20	30	Depreciation	Resident Days	32,882	12			2,269		20
21	32	Interest	Resident Days	32,882	12	57,172		2,269	3,945	21
22	33	Real Estate Taxes	Resident Days	32,882	12			2,269		22
23	34	Rent-Facility and Grounds	Resident Days	32,882	12			2,269		23
24	35	Rent-Equipment & Vehicles	Resident Days	32,882	12			2,269		24
25	TOTALS					$ 57,172	$		$ 3,945	25

Facility Name & ID Number Flanagan Rehabilitation & Health Care Cente # 0049213 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Associated Bank		X	Facility	$7,053.00	11/1/2007	$ 900,000	$	Paid	0.0704	$ 51,620	1
2	The Private Bank		X	Mortgage	Varies	11/1/09	1,239,044	1,235,809	10/31/09	Varies	8,892	2
3							Interest Income Offset				(4,183)	3
4							Home Office Allocation-PHC				2,978	4
5							Home Office Allocation-PC				5,709	5
	Working Capital											
6							Home Office Allocation-PHN				3,945	6
7												7
8												8
9	TOTAL Facility Related				$7,053.00		$ 2,139,044	$ 1,235,809			$ 68,961	9
	B. Non-Facility Related*											
10							Amortization of Loan Costs				4,711	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 4,711	14
15	TOTALS (line 9+line14)						$ 2,139,044	$ 1,235,809			$ 73,672	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 Flanagan Rehabilitation & Health Care Center # 0049213 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and

1. Real Estate Tax accrual used on 2008 report.		$ 32,000	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.)	2008	$ 27,607	2
3. Under or (over) accrual (line 2 minus line 1).		$ (4,393)	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 28,500	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.	**Allocation from closing**	267	
	Home Office Allocation	297	
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.		$ 24,671	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2004		8
2005		9
2006		10
2007	101	11
2008	27,607	12

Accrual based on an estimated assessed value times the tax rate

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2008	$	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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2008 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2008 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2008.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2008 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2009 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2008 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Flanagan Rehabilitation & Health Care Center COUNTY Livingston

FACILITY IDPH LICENSE NUMBER 0049213

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

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

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

Enter the tax index number and real estate tax assessed for 2008 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 2008.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-13-27-226-04	Long-Term Care Facility	228.98	228.98
2.	13-13-27-201-015	Long-Term Care Facility	96.12	96.12
3.	13-27-203-003	Long-Term Care Facility	$ 26,980.14	$ 26,980.14
4.	13-27-201-017	Long-Term Care Facility	$ 302.18	$ 302.18
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 27,607.42	$ 27,607.42

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 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

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 Flanagan Rehabilitation & Health Care Center # 0049213 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 30,000 B. General Construction Type: Exterior Brick 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	16,000	2007	$ 30,000	1
2					2
3	TOTALS	16,000		$ 30,000	3

Facility Name & ID Number Flanagan Rehabilitation & Health Care Center # 0049213 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	75		2007	1982	$ 810,000	$	25	$ 32,400	$ 32,400	$ 68,850	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Original Land Improvements			2007	10,000		15	667	667	1,434	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	Building Booked					32,400			(32,400)		28
29	Land Improvements Booked					667			(667)		29
30											30
31											31
32	2009-Home Office Allocation-Land Improvements				442			28	28		32
33	2009-Home Office Allocation-Building Improvements				6,604			158	158		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 Flanagan Rehabilitation & Health Care Center # 0049213 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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)		$ 827,046	$ 33,067		$ 33,253	$ 186	$ 70,284	70

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

Facility Name & ID Number Flanagan Rehabilitation & Health Care Center # 0049213 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	$ 158,327	$ 22,618	$ 15,833	$ (6,785)	10 yrs.	$ 38,749	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Home Office Allocation			2,062	2,062			74
75	TOTALS	$ 158,327	$ 22,618	$ 17,895	$ (4,723)		$ 38,749	75

D. Vehicle Depreciation (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,015,373	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 55,685	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 51,148	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (4,537)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 109,033	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 Flanagan Rehabilitation & Health Care Center # 0049213 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

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.	/2010	$
13.	/2011	$
14.	/2012	$

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: $ 11,164 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.

Flanagan Rehabilitation and Health Care Center
0049213
Period Beginning 1/1/2009
Period End 12/31/2009

Schedule 14A

XII. Rental Costs
B. Equipment
16. Description of rental amount for movable equipment

Medical Equipment	$	6,624
Dishwasher		767
Copier		3,488
Home Office Allocation		285
		11,164

Facility Name & ID Number Flanagan Rehabilitation & Health Care Center # 0049213 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

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?

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.

[ ] YES
[X] NO

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 Flanagan Rehabilitation & Health Care Center # 0049213 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

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	$	4,952	$ 74,277	$	4,952	$ 74,277	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		3,200	48,003		3,200	48,003	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		5,938	89,065	25	5,938	89,090	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				50,554		50,554	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			$	14,090	$ 211,345	$ 50,579	14,090	$ 261,924	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Flanagan Rehabilitation & Health Care Center # 0049213 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2009 (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	$ 508,515	$ 508,515	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 100,000)	479,135	479,135	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	38,033	38,033	6
7	Other Prepaid Expenses	8,968	8,968	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,034,651	$ 1,034,651	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	40,000	30,000	13
14	Buildings, at Historical Cost	810,000	816,604	14
15	Leasehold Improvements, at Historical Cost		10,442	15
16	Equipment, at Historical Cost	158,327	158,327	16
17	Accumulated Depreciation (book methods)	(118,310)	(109,033)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 890,017	$ 906,340	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,924,668	$ 1,940,991	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 309,219	$ 309,219	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	63,157	63,157	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,285	1,285	31
32	Accrued Real Estate Taxes(Sch.IX-B)	28,500	28,500	32
33	Accrued Interest Payable	4,523	4,523	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	51,701	51,701	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 458,385	$ 458,385	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,235,809	1,235,809	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)**	$ 1,235,809	$ 1,235,809	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,694,194	$ 1,694,194	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 230,474	$ 246,797	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,924,668	$ 1,940,991	48

*(See instructions.)

Facility Name & ID Number Flanagan Rehabilitation & Health Care Center # 0049213 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 258,292	1
2	Restatements (describe):		2
3	Prior period adjustments	(115,699)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 142,593	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(164,632)	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)**	$ (164,632)	17
	B. Transfers (Itemize):		
18	Transfer of net assets	252,513	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 252,513	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 230,474	24 *

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

Facility Name & ID Number Flanagan Rehabilitation & Health Care Center # 0049213 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

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	$ 1,836,135	1
2	Discounts and Allowances for all Levels	(61,133)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,775,002	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	277,238	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 277,238	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	1,538	14
15	Telephone, Television and Radio	2,500	15
16	Rental of Facility Space		16
17	Sale of Drugs	93,989	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	11,670	20
21	Other Medical Services	5,086	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 114,783	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,733	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,733	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc/Vending/Transportation Revenue	3,215	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,215	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,173,971	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	482,285	31
32	Health Care	1,080,556	32
33	General Administration	367,605	33
	B. Capital Expense		
34	Ownership	156,161	34
	C. Ancillary Expense		
35	Special Cost Centers	228,453	35
36	Provider Participation Fee	23,543	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,338,603	40
41	**Income before Income Taxes (line 30 minus line 40)****	(164,632)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (164,632)	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 Flanagan Rehabilitation & Health Care Center # 0049213 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

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	2,080	2,080	55,492	$ 26.68	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,669	3,700	95,840	25.90	3
4	Licensed Practical Nurses	11,083	11,551	233,765	20.24	4
5	CNAs & Orderlies	29,053	30,261	337,820	11.16	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,930	2,081	25,748	12.37	9
10	Activity Assistants	1,461	1,463	11,719	8.01	10
11	Social Service Workers	1852	1,877	23,121	12.32	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	33,965	16.33	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,731	12,354	111,663	9.04	15
16	Dishwashers					16
17	Maintenance Workers	1,786	1,920	34,401	17.92	17
18	Housekeepers	6,933	7,053	60,445	8.57	18
19	Laundry	2,761	3,058	29,784	9.74	19
20	Administrator	2,080	2,080	59,798	28.75	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,952	2,073	25,600	12.35	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: Marketing	2,080	2,080	35,108	16.88	32
33	Other(specify) Care Plan Coord.	2,080	2,080	35,442	17.04	33
34	TOTAL (lines 1 - 33)	84,611	87,791	$ 1,209,711 *	$ 13.78	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	4,800	9(3)	36
37	Medical Records Consultant	Monthly	780	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,250	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 6,830		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	48	$ 1,567	10(3)	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	48	$ 1,567		53

Facility Name & ID Number Flanagan Rehabilitation & Health Care Center # 0049213 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Gregory Green	Administrator	0	$ 59,798
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 59,798

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 86,800
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 86,800

C. Professional Services

Vendor/Payee	Type	Amount
E-Health Data Solutions	Computer Services	$ 2,700
SimpleLTC, Inc.	Computer Services	81
Frontier	Computer Services	832
Clifton Gunderson LLP	Accounting Services	5,000
LTC Solutions	Computer Services	1,700
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 10,313

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 36,098
Unemployment Compensation Insurance	17,925
FICA Taxes	86,895
Employee Health Insurance	31,196
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	5,213
Employee Retirement	538
TOTAL (agree to Schedule V, line 22, col.8)	$ 177,865

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	$ 1,990
Advertising: Employee Recruitment	220
Health Care Worker Background Check (Indicate # of checks performed ____)	
Patient Background Checks 28	280
Miscellaneous Licenses & Permits	527
Miscellaneous Dues & Subscriptions	250
Home Office Allocation	1,199
Less: Public Relations Expense	(250)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,216

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Home Office Allocation	75
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 75

**See instructions.

Flanagan Rehabilitation & Health Care Center
0049213
Period Beginning 1/1/2009
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Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		10,313
Home Office Allocation		
Heyl, Royster, Voelker & Allen	Legal	21
GoffWilson, P.A.	Legal	30
Jackson Lewis	Legal	236
Peter Gartelos	Legal	23
Misc.	Legal	20
Ginoli & Company	Accountants	1,732
Miscellaneous Vendors	Computer Services	22
Emdeon Business Services	Computer Services	10
Advanced Answers on Demand	Computer Services	1,265
Access 2 Go	Computer Services	122
Ivans	Computer Services	14
Kemper Technology	Computer Services	344
VisionShare	Computer Services	107
MediFax	Computer Services	44
Logmeln	Computer Services	19
Charter Communications	Computer Services	1
Simple LTC	Computer Services	292
Miscellaneous Vendors	Miscellaneous	200
Total (agree to Schedule V, line 19, column 8)		14,815

Facility Name & ID Number Flanagan Rehabilitation & Health Care Center # 0049213 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

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								
					FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4	N/A												
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Flanagan Rehabilitation & Health Care Center # 0049213 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

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. $ **7,181** 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? **N/A**
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. $ **23,543**
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. $ **2,649**

(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? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **No**
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? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? **N/A**
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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

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