



Facility Name & ID Number Prairie City Rehab & Health Care

# 0049189 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	47	Skilled (SNF)	47	17,155	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	47	TOTALS	47	17,155	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	5,740	4,092	520	10,352	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,740	4,092	520	10,352	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 60.34%

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  NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES  NO  Non-allowable costs have been eliminated in Schedule V, Column 7

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

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

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 47 and days of care provided 520

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

Is your fiscal year identical to your tax year? YES  NO

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

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	99,583	5,958		105,541		105,541	1,810	107,351		1
2	Food Purchase		52,812		52,812		52,812	(2,707)	50,105		2
3	Housekeeping	69,502	9,519		79,021		79,021	17	79,038		3
4	Laundry	2,080	6,575		8,655		8,655		8,655		4
5	Heat and Other Utilities			36,974	36,974		36,974	179	37,153		5
6	Maintenance	14,945	3,822	11,974	30,741		30,741	877	31,618		6
7	Other (specify):* Home Off. Ben. All.							327	327		7
8	<b>TOTAL General Services</b>	<b>186,110</b>	<b>78,686</b>	<b>48,948</b>	<b>313,744</b>		<b>313,744</b>	<b>503</b>	<b>314,247</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director										9
10	Nursing and Medical Records	417,784	28,001	2,194	447,979		447,979	1,096	449,075		10
10a	Therapy			63,443	63,443		63,443		63,443		10a
11	Activities	19,840	468	947	21,255		21,255		21,255		11
12	Social Services	27,300			27,300		27,300		27,300		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.							135	135		15
16	<b>TOTAL Health Care and Programs</b>	<b>464,924</b>	<b>28,469</b>	<b>66,584</b>	<b>559,977</b>		<b>559,977</b>	<b>1,231</b>	<b>561,208</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	12,500		40,000	52,500		52,500	(1,892)	50,608		17
18	Directors Fees										18
19	Professional Services			12,804	12,804		12,804	(3,450)	9,354		19
20	Dues, Fees, Subscriptions & Promotions			3,893	3,893		3,893	967	4,860		20
21	Clerical & General Office Expenses	6,391	2,434	4,563	13,388		13,388	20,991	34,379		21
22	Employee Benefits & Payroll Taxes			204,406	204,406		204,406	3,905	208,311		22
23	Inservice Training & Education							188	188		23
24	Travel and Seminar							58	58		24
25	Other Admin. Staff Transportation			5,659	5,659		5,659	910	6,569		25
26	Insurance-Prop.Liab.Malpractice			18,497	18,497		18,497	377	18,874		26
27	Other (specify):* Home Off. Ben. All.							4,955	4,955		27
28	<b>TOTAL General Administration</b>	<b>18,891</b>	<b>2,434</b>	<b>289,822</b>	<b>311,147</b>		<b>311,147</b>	<b>27,009</b>	<b>338,156</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>669,925</b>	<b>109,589</b>	<b>405,354</b>	<b>1,184,868</b>		<b>1,184,868</b>	<b>28,743</b>	<b>1,213,611</b>		<b>29</b>

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Prairie City Rehab & Health Care

#0049189

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			39,829	39,829		39,829	(3,339)	36,490			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			44,400	44,400		44,400	(13,864)	30,536			32
33	Real Estate Taxes			4,511	4,511		4,511	229	4,740			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			682	682		682	219	901			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			89,422	89,422		89,422	(16,755)	72,667			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		25,092		25,092		25,092		25,092			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			25,733	25,733		25,733		25,733			42
43	Other (specify):* <b>Non-allowable Cost</b>		688	16,339	17,027		17,027	(17,027)				43
44	<b>TOTAL Special Cost Centers</b>		25,780	42,072	67,852		67,852	(17,027)	50,825			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	669,925	135,369	536,848	1,342,142		1,342,142	(5,039)	1,337,103			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Prairie City Rehab & Health Care

# 0049189

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,639)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,492)	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	(5,120)	30		9
10	Interest and Other Investment Income	(801)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(126)	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	(68)	43		18
19	Entertainment				19
20	Contributions	(250)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(6,162)	43		24
25	Fund Raising, Advertising and Promotional	(2,186)	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	(30,732)	Various		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (53,576)		\$	30

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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	48,537	Various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 48,537		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (5,039)		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	2	3	4	
		Yes	No	Amount	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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY						
48		49		50		51
						52

Prairie City Rehab & Health Care

ID# 0049189

Report Period Beginning: 1/1/2009

Ending: 12/31/2009

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Labs-Part A	\$ (2,366)	43	1
2	X-Rays-Part A	(315)	43	2
3	Disallowed Special Events	2	43	3
4	Offset Vending Revenue	(109)	2	4
5	Offset Miscellaneous Office Supplies Revenue	(120)	21	5
6	Pet Expense	(64)	43	6
7	Disallowed Legal Expenses	(7,108)	19	7
8	Offset of Related Party Interest	(20,652)	32	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>		(30,732)	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Prairie City Rehab & Health Care# 0049189

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	1,810	0	0	0	0	0	0	0	0	0	1,810	1
2	Food Purchase	(2,748)	41	0	0	0	0	0	0	0	0	0	(2,707)	2
3	Housekeeping	0	17	0	0	0	0	0	0	0	0	0	17	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	179	0	0	0	0	0	0	0	0	0	179	5
6	Maintenance	0	877	0	0	0	0	0	0	0	0	0	877	6
7	Other (specify):*	0	327	0	0	0	0	0	0	0	0	0	327	7
8	<b>TOTAL General Services</b>	<b>(2,748)</b>	<b>3,251</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>503</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	1,096	0	0	0	0	0	0	0	0	0	1,096	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	135	0	0	0	0	0	0	0	0	0	135	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>1,231</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1,231</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(1,892)	0	0	0	0	0	0	0	0	0	(1,892)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(7,108)	2,538	0	1,120	0	0	0	0	0	0	0	(3,450)	19
20	Fees, Subscriptions & Promotions	0	0	707	260	0	0	0	0	0	0	0	967	20
21	Clerical & General Office Expenses	(120)	0	18,460	2,651	0	0	0	0	0	0	0	20,991	21
22	Employee Benefits & Payroll Taxes	0	0	0	3,905	0	0	0	0	0	0	0	3,905	22
23	Inservice Training & Education	0	0	188	0	0	0	0	0	0	0	0	188	23
24	Travel and Seminar	0	0	58	0	0	0	0	0	0	0	0	58	24
25	Other Admin. Staff Transportation	0	0	910	0	0	0	0	0	0	0	0	910	25
26	Insurance-Prop.Liab.Malpractice	0	0	377	0	0	0	0	0	0	0	0	377	26
27	Other (specify):*	0	0	4,955	0	0	0	0	0	0	0	0	4,955	27
28	<b>TOTAL General Administration</b>	<b>(7,228)</b>	<b>646</b>	<b>25,655</b>	<b>7,936</b>	<b>0</b>	<b>27,009</b>	<b>28</b>						
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(9,976)</b>	<b>5,128</b>	<b>25,655</b>	<b>7,936</b>	<b>0</b>	<b>28,743</b>	<b>29</b>						

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Prairie City Rehab & Health Care# 0049189

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	(5,120)	0	1,492	289	0	0	0	0	0	0	0	(3,339)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(21,453)	0	2,295	5,294	0	0	0	0	0	0	0	(13,864)	32
33	Real Estate Taxes	0	0	229	0	0	0	0	0	0	0	0	229	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	219	0	0	0	0	0	0	0	0	219	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(26,573)</b>	<b>0</b>	<b>4,235</b>	<b>5,583</b>	<b>0</b>	<b>(16,755)</b>	<b>37</b>						
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(17,027)	0	0	0	0	0	0	0	0	0	0	(17,027)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(17,027)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(17,027)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(53,576)</b>	<b>5,128</b>	<b>29,890</b>	<b>13,519</b>	<b>0</b>	<b>(5,039)</b>	<b>45</b>						

**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.  YES  NO

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

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 1,810	\$ 1,810	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	41	41	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	17	17	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	179	179	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	877	877	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	327	327	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	1,096	1,096	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%	135	135	10
11	V	17 Administrative	40,000	Petersen Health Care, Inc.	100.00%	38,108	(1,892)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	2,538	2,538	12
13	V							13
14	Total		\$ 40,000			\$ 45,128	\$ * 5,128	14

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

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.  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%	\$ 707	\$ 707	15
16	V	21	Clerical and General Office		Petersen Health Care, Inc.	100.00%	18,460	18,460	16
17	V	23	Inservice Training and Education		Petersen Health Care, Inc.	100.00%	188	188	17
18	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	58	58	18
19	V	25	Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	910	910	19
20	V	26	Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	377	377	20
21	V	27	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	4,955	4,955	21
22	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	1,492	1,492	22
23	V	32	Interest		Petersen Health Care, Inc.	100.00%	2,295	2,295	23
24	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	229	229	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%	219	219	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$				\$ 29,890	\$ * 29,890	39

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

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.  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%	1,120	1,120	26	
27	V	20 Dues, Fees, Subs & Promotions		Petersen Companies, LLC	100.00%	260	260	27	
28	V	21 Clerical and General Office		Petersen Companies, LLC	100.00%	2,651	2,651	28	
29	V	22 Employee Benefits & Payroll		Petersen Companies, LLC	100.00%	3,905	3,905	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%	289	289	34	
35	V	32 Interest		Petersen Companies, LLC	100.00%	5,294	5,294	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		\$			\$ 13,519	\$ *	13,519	39

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

Facility Name & ID Number Prairie City Rehab & Health Care # 0049189 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 Name	2 Title	3 Function	4 Ownership Interest	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	Mark Petersen	President	Administrative	100.00	157,936	0.4	0.67	Salary	\$ 1,177	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	\$ 1,177		13

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

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

Facility Name & ID Number Prairie City Rehab & Health Care

# 0049189

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  NO

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,493,044	75	\$ 261,102	\$ 259,584	10,352	\$ 1,810	1
2	2	Food	Resident Days	1,493,044	75	5,864	0	10,352	41	2
3	3	Housekeeping	Resident Days	1,493,044	75	2,458	0	10,352	17	3
4	4	Laundry	Resident Days	1,493,044	75	0	0	10,352	0	4
5	5	Utilities	Resident Days	1,493,044	75	25,776	0	10,352	179	5
6	6	Maintenance	Resident Days	1,493,044	75	126,463	107,810	10,352	877	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	47,148	0	10,352	327	7
8	10	Nursing and Medical Records	Resident Days	1,493,044	75	158,020	151,697	10,352	1,096	8
9	10A	Therapy	Resident Days	1,493,044	75	0	0	10,352	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	19,462	0	10,352	135	10
11	17	Administrative	Resident Days	1,493,044	75	3,315,953	3,315,953	10,352	38,108	11
12	19	Professional Services	Resident Days	1,493,044	75	366,089	0	10,352	2,538	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,493,044	75	102,022	0	10,352	707	13
14	21	Clerical and General Office	Resident Days	1,493,044	75	2,662,394	2,253,243	10,352	18,460	14
15	23	Inservice Training & Education	Resident Days	1,493,044	75	27,176	0	10,352	188	15
16	24	Travel and Seminar	Resident Days	1,493,044	75	8,381	0	10,352	58	16
17	25	Other Admin. Staff Transport.	Resident Days	1,493,044	75	131,200	0	10,352	910	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,493,044	75	54,425	0	10,352	377	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	714,650	0	10,352	4,955	19
20	30	Depreciation	Resident Days	1,493,044	75	215,197	0	10,352	1,492	20
21	32	Interest	Resident Days	1,493,044	75	330,981	0	10,352	2,295	21
22	33	Real Estate Taxes	Resident Days	1,493,044	75	33,065	0	10,352	229	22
23	34	Rent-Facility and Grounds	Resident Days	1,493,044	75	0	0	10,352	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,493,044	75	31,635	0	10,352	219	24
25	TOTALS					\$ 8,639,461	\$ 6,088,287		\$ 75,018	25

Facility Name & ID Number Prairie City Rehab & Health Care

# 0049189

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  NO

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	198,749	13		10,352		1
2	2	Food	Resident Days	198,749	13		10,352		2
3	3	Housekeeping	Resident Days	198,749	13		10,352		3
4	4	Laundry	Resident Days	198,749	13		10,352		4
5	5	Utilities	Resident Days	198,749	13		10,352		5
6	6	Maintenance	Resident Days	198,749	13		10,352		6
7	7	Mgmt. Allocation of Benefits	Resident Days	198,749	13		10,352		7
8	10	Nursing and Medical Records	Resident Days	198,749	13		10,352		8
9	10A	Therapy	Resident Days	198,749	13		10,352		9
10	15	Mgmt. Allocation of Benefits	Resident Days	198,749	13		10,352		10
11	17	Administrative	Resident Days	198,749	13		10,352		11
12	19	Professional Services	Resident Days	198,749	13	21,502	10,352	1,120	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	198,749	13	4,999	10,352	260	13
14	21	Clerical and General Office	Resident Days	198,749	13	50,893	10,352	2,651	14
15	22	Employee Benefits & Payroll	Resident Days	198,749	13	74,975	10,352	3,905	15
16	24	Travel and Seminar	Resident Days	198,749	13		10,352		16
17	25	Other Admin. Staff Transport.	Resident Days	198,749	13		10,352		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	198,749	13		10,352		18
19	27	Mgmt. Allocation of Benefits	Resident Days	198,749	13		10,352		19
20	30	Depreciation	Resident Days	198,749	13	5,550	10,352	289	20
21	32	Interest	Resident Days	198,749	13	101,632	10,352	5,294	21
22	33	Real Estate Taxes	Resident Days	198,749	13		10,352		22
23	34	Rent-Facility and Grounds	Resident Days	198,749	13		10,352		23
24	35	Rent-Equipment & Vehicles	Resident Days	198,749	13		10,352		24
25	TOTALS					\$ 259,551	\$	\$ 13,519	25

**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	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					Monthly Payment Required	Date of Note				Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO									Original	Balance			
<b>A. Directly Facility Related</b>																
<b>Long-Term</b>																
1	Ipava Bank		X	Mortgage	\$2,677.97	4/21/06	\$ 320,000	\$ 290,322	4/21/16	0.0800	\$ 23,748	1				
2	Eddie Fransiscovich	X		Long-Term Working Capital		VAR	481,182	262,620	10/2013	0.0700	20,652	2				
3	James Petersen	X		Long-Term Working Capital		VAR	45,000	45,000	Demand	None		3				
4												4				
5												5				
<b>Working Capital</b>																
6												6				
7												7				
8												8				
9	<b>TOTAL Facility Related</b>				<b>\$2,677.97</b>		<b>\$ 846,182</b>	<b>\$ 597,942</b>			<b>\$ 44,400</b>	<b>9</b>				
<b>B. Non-Facility Related*</b>																
10							<b>Interest Income Offset</b>				<b>(801)</b>	<b>10</b>				
11							<b>Home Office Allocation-PHC</b>				<b>2,295</b>	<b>11</b>				
12							<b>Home Office Allocation-PC</b>				<b>5,294</b>	<b>12</b>				
13							<b>Offset of Related Party Interest</b>				<b>(20,652)</b>	<b>13</b>				
14	<b>TOTAL Non-Facility Related</b>						<b>\$</b>	<b>\$</b>			<b>(13,864)</b>	<b>14</b>				
15	<b>TOTALS (line 9+line14)</b>						<b>\$ 846,182</b>	<b>\$ 597,942</b>			<b>\$ 30,536</b>	<b>15</b>				

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.)

**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 bill

1. Real Estate Tax accrual used on 2008 report.		\$	<b>18,200</b>	<b>1</b>
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.)	<b>2008</b>	\$	<b>4,511</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(13,689)</b>	<b>3</b>
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>18,200</b>	<b>4</b>
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		<b>5</b>
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. <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	<b>229</b>	<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>4,740</b>	<b>7</b>

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2004	<b>4,114</b>	<b>8</b>
	2005	<b>4,216</b>	<b>9</b>
	2006	<b>4,359</b>	<b>10</b>
	2007	<b>4,435</b>	<b>11</b>
	2008	<b>4,511</b>	<b>12</b>

**Accrual based on prior year tax bill.**

	<b>FOR BHF USE ONLY</b>		
	<b>13</b>	FROM R. E. TAX STATEMENT FOR 2008 \$	<b>13</b>
	<b>14</b>	PLUS APPEAL COST FROM LINE 5 \$	<b>14</b>
	<b>15</b>	LESS REFUND FROM LINE 6 \$	<b>15</b>
	<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION \$	<b>16</b>

**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.**



4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		<b>TOTALS</b>	\$ <u>4,511.23</u>	\$ <u>4,511.23</u>

**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.**

**X. BUILDING AND GENERAL INFORMATION:**

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

C. Does the Operating Entity?  (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?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (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

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F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  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:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>216,058</u>	<u>2008</u>	<u>\$ 120,000</u>	1
2					2
3	<b>TOTALS</b>	<b>216,058</b>		<b>\$ 120,000</b>	3

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	47		2008	1970	\$ 562,500	\$	25	\$ 22,500	\$ 22,500	\$ 33,750	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Fire Alarm Control		2008		2,608		15	174	174	261	9
10	Patch Parking Lot		2009		3,200		7	229	229	229	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	Land Improvements Booked					390			(390)		27
28	Building Booked					22,500			(22,500)		28
29	Building Improvement Booked					278			(278)		29
30											30
31											31
32	2009-Home Office Allocation-Land Improvements				341			21	21		32
33	2009-Home Office Allocation-Building Improvements				5,089			122	122		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 **Prairie City Rehab & Health Care**

# **0049189**

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	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	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	<b>TOTAL (lines 4 thru 69)</b>		\$ 573,738	\$ 23,168		\$ 23,046	\$ (122)	\$ 34,240	70

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

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	\$ 116,629	\$ 16,661	\$ 11,663	\$ (4,998)	10 yrs.	\$ 29,157	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Home Office Allocation			1,781	1,781			74
75	TOTALS	\$ 116,629	\$ 16,661	\$ 13,444	\$ (3,217)		\$ 29,157	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										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)	\$ 810,367	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 39,829	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 36,490	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (3,339)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 63,397	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.

**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	<b>TOTAL</b>				\$			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. \_\_\_\_\_ /2010                      \$ \_\_\_\_\_

13. \_\_\_\_\_ /2011                      \$ \_\_\_\_\_

14. \_\_\_\_\_ /2012                      \$ \_\_\_\_\_

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?

YES  NO

16. Rental Amount for movable equipment: \$ 901 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			<u>N/A</u>		18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	21

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

**Prairie City Rehab & Health Care**

**0049189**

**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	\$	461
Copier		221
Home Office Allocation		219
		<u>901</u>

Facility Name & ID Number Prairie City Rehab & Health Care # 0049189 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.)

<p><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>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.</p>	<p><b>2. CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		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	<b>TOTALS</b>	\$	\$	\$	\$
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**

<b>COMPLETED</b>		
1. From this facility		
2. From other facilities (f)		
<b>DROP-OUTS</b>		
1. From this facility		
2. From other facilities (f)		
<b>TOTAL TRAINED</b>		

- (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.

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	2,036	\$ 30,545	\$	2,036	\$ 30,545	1	
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		197	2,956		197	2,956	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		1,996	29,942		1,996	29,942	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				25,092		25,092	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify):									12	
13	Other (specify):									13	
14	TOTAL			\$	4,229	\$ 63,443	\$ 25,092	4,229	\$ 88,535	14	

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

Facility Name & ID Number Prairie City Rehab & Health Care# 0049189Report Period Beginning: 1/1/2009Ending: 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*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ (342,185)	\$ (342,185)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>N/A</u> )	96,120	96,120	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	23,834	23,834	6
7	Other Prepaid Expenses	4,990	4,990	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): _____			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ (217,241)	\$ (217,241)	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	125,050	120,000	13
14	Buildings, at Historical Cost	562,500	567,589	14
15	Leasehold Improvements, at Historical Cost	3,333	6,149	15
16	Equipment, at Historical Cost	116,629	116,629	16
17	Accumulated Depreciation (book methods)	(52,746)	(63,397)	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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 754,766	\$ 746,970	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 537,525	\$ 529,729	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 230,057	\$ 230,057	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	45,000	45,000	29
30	Accrued Salaries Payable	35,160	35,160	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,771	1,771	31
32	Accrued Real Estate Taxes(Sch.IX-B)	18,200	18,200	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Payroll Withholdings</u>	31,322	31,322	36
37	_____			37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 361,510	\$ 361,510	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	262,620	262,620	39
40	Mortgage Payable	290,322	290,322	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>A/P-Insurance</u>	4,195	4,195	43
44	_____			44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 557,137	\$ 557,137	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 918,647	\$ 918,647	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (381,122)	\$ (388,918)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 537,525	\$ 529,729	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ (226,863)	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ (226,863)	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(154,259)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (154,259)	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ (381,122)	<b>24</b> *

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

Facility Name & ID Number Prairie City Rehab & Health Care# 0049189Report Period Beginning: 1/1/2009Ending: 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.

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 1,102,344	1
2	Discounts and Allowances for all Levels	(6,912)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 1,095,432</b>	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	45,480	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 45,480</b>	8
<b>C. Other Operating Revenue</b>			
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	2,639	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	37,909	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	3,780	20
21	Other Medical Services	1,680	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 46,008</b>	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	734	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 734</b>	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Miscellaneous Revenue</b>	120	28
28a	<b>Vending Income</b>	109	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 229</b>	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 1,187,883</b>	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	313,744	31
32	Health Care	559,977	32
33	General Administration	311,147	33
<b>B. Capital Expense</b>			
34	Ownership	89,422	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	42,119	35
36	Provider Participation Fee	25,733	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 1,342,142</b>	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(154,259)</b>	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (154,259)</b>	43

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

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

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

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

Facility Name & ID Number Prairie City Rehab & Health Care

# 0049189

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	50,375	\$ 24.22	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,074	3,129	55,051	17.59	3
4	Licensed Practical Nurses	5,829	5,965	96,976	16.26	4
5	CNAs & Orderlies	20,567	20,944	181,602	8.67	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,993	1,993	19,493	9.78	9
10	Activity Assistants	32	32	281	8.78	10
11	Social Service Workers	2080	2,080	27,300	13.13	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	23,365	11.23	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,217	9,423	76,218	8.09	15
16	Dishwashers					16
17	Maintenance Workers	1,211	1,276	14,945	11.71	17
18	Housekeepers	8,542	8,687	69,502	8.00	18
19	Laundry	263	263	2,080	7.91	19
20	Administrator	2,048	2,048	49,431	24.14	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	610	639	6,391	10.00	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: <u>Transportation</u>	8	8	66	8.25	32
33	Other(specify) <u>Care Plan Coord.</u>	2,080	2,080	33,780	16.24	33
34	TOTAL (lines 1 - 33)	61,714	62,727	\$ 706,856 *	\$ 11.27	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			36	
37	Medical Records Consultant			37	
38	Nurse Consultant			38	
39	Pharmacist Consultant	Monthly	600	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)	\$ 600		49	

**C. CONTRACT NURSES**

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

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Eddie Fransiscovich	Administrator	0	\$ 49,431	Workers' Compensation Insurance	\$ 23,342	IDPH License Fee	\$ 1,046	
				Unemployment Compensation Insurance	12,558	Advertising: Employee Recruitment	1,504	
				FICA Taxes	48,860	Health Care Worker Background Check		
				Employee Health Insurance	118,747	(Indicate # of checks performed )		
				Employee Meals		Patient Background Checks	69	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	653	
				Employee Relations	4,804	Miscellaneous Dues & Subscriptions	0	
						IHCA Dues	0	
						Home Office Allocation	967	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 49,431			Less: Public Relations Expense	( )	
(List each licensed administrator separately.)						Non-allowable advertising	( )	
						Yellow page advertising	( )	
<b>B. Administrative - Other</b>				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
Description			Amount					
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 40,000					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 40,000	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
(Attach a copy of any management service agreement)				Description			Description	
				Line #			Amount	
<b>C. Professional Services</b>			Amount	Amount			Amount	
Vendor/Payee	Type						Out-of-State Travel	
E-Health Data Solutions	Computer Services		\$ 2,700				\$	
Mediacom	Computer Services		1,215					
LTC Solutions	Computer Services		1,700					
SimpleLTC, Inc.	Computer Services		81	N/A			In-State Travel	
Alberta Andderson	Legal Fees		3,554					
Rosalie Carlisle	Legal Fees		3,554				Seminar Expense	
							Home Office Allocation	
							58	
							Entertainment Expense	
							( )	
TOTAL (agree to Schedule V, line 19, column 3)			\$ 12,804	TOTAL			\$ 58	
(If total legal fees exceed \$5,000, attach copy of invoices.)							(agree to Sch. V, line 24, col. 8)	

\* Attach copy of IMRF notifications

\*\*See instructions.

**Prairie City Rehab & Health Care**

**0049189**

**Period Beginning 1/1/2009**

**Period End 12/31/2009**

**Schedule 21A**

**XIX. SUPPORT SCHEDULE**

**C. Professional Services**

<b>Vendor/Payee</b>	<b>Type</b>	<b>Amount</b>
Total (agree to Schedule V, line 19, column 3)		12,804
Disallowed Legal Fees		(7,108)
<b>Home Office Allocation</b>		
Heyl, Royster, Voelker & Allen	Legal	16
GoffWilson, P.A.	Legal	23
Jackson Lewis	Legal	182
Peter Gartelos	Legal	18
Misc.	Legal	16
Ginoli & Company	Accountants	1,524
Miscellaneous Vendors	Computer Services	17
Emdeon Business Services	Computer Services	8
Advanced Answers on Demand	Computer Services	975
Access 2 Go	Computer Services	94
Ivans	Computer Services	11
Kemper Technology	Computer Services	265
VisionShare	Computer Services	83
MediFax	Computer Services	34
LogmIn	Computer Services	15
Charter Communications	Computer Services	1
Simple LTC	Computer Services	225
Miscellaneous Vendors	Miscellaneous	151
Total (agree to Schedule V, line 19, column 8)		<u>9,354</u>

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	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 Prairie City Rehab & Health Care# 0049189Report Period Beginning: 1/1/2009Ending: 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? Yes  
If YES, give association name and amount. 0 IHCA
- (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? No
- (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. \$ 5,806 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. \$ 25,733  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? 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. \$ 2,748
- (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 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.