I. IDPH License ID Number: 0047621
Facility Name: South Elgin Rehabilitation & Health Care Center
Address: 746 West Spring Street South Elgin 60177
County: Kane
Telephone Number: (847) 697-0565 Fax # (847) 697-0568
HFS ID Number: 
Date of Initial License for Current Owners: 10/1/2005
Type of Ownership:

X Voluntary, Non-Profit

Proprietary

Governmental

Charitable Corp.

Partnership

Corporation

Limited Liability Co.

Trust

Limited Liability Co.

Other

In the event there are further questions about this report, please contact:
Name: Larry Templin
Telephone Number: (309) 689-5869
Email Address: 

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2011 to 12/31/2011 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Mark B. Petersen
Chief Executive Officer
Type of Ownership

SIGNED

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

HFS 3745 (N-4-99) IL478-2471
### III. STATISTICAL DATA

#### 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**
- **X**

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 10/1/2005**

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

- **YES**
- **X**
- **NO**

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

- **YES**
- **X**
- **NO**

If YES, enter number of beds certified **14** and days of care provided **2,134**

Medicare Intermediary **National Government Services**

#### IV. ACCOUNTING BASIS

- **ACCRUAL**
- **CASH**
- **CASH**

Is your fiscal year identical to your tax year? **YES**

**X**

**NO**

Tax Year: **12/31/11**

Fiscal Year: **12/31/11**

* All facilities other than governmental must report on the accrual basis.
<table>
<thead>
<tr>
<th>Operating Expenses</th>
<th>Costs Per General Ledger</th>
<th>Reclassification</th>
<th>Adjustments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Salary/Wage</td>
<td>Supplies</td>
<td>Other</td>
</tr>
<tr>
<td>A. General Services</td>
<td>129,257</td>
<td>11,406</td>
<td>140,663</td>
</tr>
<tr>
<td>1 Dietary</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Food Purchase</td>
<td>139,741</td>
<td>139,741</td>
<td></td>
</tr>
<tr>
<td>3 Housekeeping</td>
<td>141,267</td>
<td>23,546</td>
<td>164,813</td>
</tr>
<tr>
<td>4 Laundry</td>
<td>16,403</td>
<td>7,428</td>
<td>23,831</td>
</tr>
<tr>
<td>5 Heat and Other Utilities</td>
<td>62,243</td>
<td>62,243</td>
<td></td>
</tr>
<tr>
<td>6 Maintenance</td>
<td>44,636</td>
<td>8,131</td>
<td>52,767</td>
</tr>
<tr>
<td>7 Other (specify):*</td>
<td>Home Off. Ben. All.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 TOTAL General Services</td>
<td>331,563</td>
<td>190,252</td>
<td>90,135</td>
</tr>
<tr>
<td>B. Health Care and Programs</td>
<td>1,344,624</td>
<td>123,789</td>
<td>14,404</td>
</tr>
<tr>
<td>9 Medical Director</td>
<td>14,400</td>
<td>14,400</td>
<td></td>
</tr>
<tr>
<td>10 Nursing and Medical Records</td>
<td>14,400</td>
<td>14,400</td>
<td>15,703</td>
</tr>
<tr>
<td>10a Therapy</td>
<td>48</td>
<td>872,012</td>
<td>872,060</td>
</tr>
<tr>
<td>11 Activities</td>
<td>34,992</td>
<td>549</td>
<td>35,541</td>
</tr>
<tr>
<td>12 Social Services</td>
<td>39,160</td>
<td>15</td>
<td>39,315</td>
</tr>
<tr>
<td>13 CNA Training</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14 Program Transportation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15 Other (specify):*</td>
<td>Home Off. Ben. All.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16 TOTAL Health Care and Programs</td>
<td>1,418,776</td>
<td>124,043</td>
<td>90,264</td>
</tr>
<tr>
<td>C. General Administration</td>
<td>413,400</td>
<td>413,400</td>
<td></td>
</tr>
<tr>
<td>17 Administrative</td>
<td>413,400</td>
<td>413,400</td>
<td></td>
</tr>
<tr>
<td>18 Directors Fees</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19 Professional Services</td>
<td>4,955</td>
<td>4,955</td>
<td>4,955</td>
</tr>
<tr>
<td>20 Dues, Fees, Subscriptions &amp; Promotions</td>
<td>3,540</td>
<td>3,540</td>
<td>3,540</td>
</tr>
<tr>
<td>21 Clerical &amp; General Office Expenses</td>
<td>223,839</td>
<td>223,839</td>
<td>223,839</td>
</tr>
<tr>
<td>22 Employee Benefits &amp; Payroll Taxes</td>
<td>(192)</td>
<td>(192)</td>
<td>(192)</td>
</tr>
<tr>
<td>23 Inservice Training &amp; Education</td>
<td>(192)</td>
<td>(192)</td>
<td>(192)</td>
</tr>
<tr>
<td>24 Travel and Seminar</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25 Other Admin. Staff Transportation</td>
<td>4,731</td>
<td>4,731</td>
<td>4,731</td>
</tr>
<tr>
<td>26 Insurance-Prop.Liability &amp; Malpractice</td>
<td>29,716</td>
<td>29,716</td>
<td>29,716</td>
</tr>
<tr>
<td>27 Other (specify):*</td>
<td>Home Off. Ben. All.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>28 TOTAL General Administration</td>
<td>31,091</td>
<td>5,686</td>
<td>31,687</td>
</tr>
<tr>
<td>29 TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</td>
<td>1,781,430</td>
<td>319,981</td>
<td>2,101,411</td>
</tr>
</tbody>
</table>

*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.
### V. COST CENTER EXPENSES (continued)

<table>
<thead>
<tr>
<th>Capital Expense</th>
<th>Cost Per General Ledger</th>
<th>Reclassified Total</th>
<th>Adjustments</th>
<th>Adjusted Total</th>
<th>FOR BHF USE ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Salary/Wage 1</td>
<td>Supplies 2</td>
<td>Other 3</td>
<td>Total 4</td>
<td>5</td>
</tr>
<tr>
<td><strong>D. Ownership</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30 Depreciation</td>
<td>29,240</td>
<td>29,240</td>
<td>29,240</td>
<td>6,422</td>
<td>35,662</td>
</tr>
<tr>
<td>31 Amortization of Pre-Op. &amp; Org.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>32 Interest</td>
<td>37,721</td>
<td>37,721</td>
<td>37,721</td>
<td>53,929</td>
<td>91,650</td>
</tr>
<tr>
<td>33 Real Estate Taxes</td>
<td>39,919</td>
<td>39,919</td>
<td>39,919</td>
<td>412</td>
<td>40,331</td>
</tr>
<tr>
<td>34 Rent-Facility &amp; Grounds</td>
<td>18,320</td>
<td>18,320</td>
<td>18,320</td>
<td>731</td>
<td>19,051</td>
</tr>
<tr>
<td>35 Rent-Equipment &amp; Vehicles</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>36 Other (specify):*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL Ownership</strong></td>
<td>125,200</td>
<td>125,200</td>
<td>125,200</td>
<td>61,494</td>
<td>186,694</td>
</tr>
</tbody>
</table>

| **E. Special Cost Centers** |                   |                   |            |            |            |            |     |     |     |     |
| **Ancillary Expense** |                   |                   |            |            |            |            |     |     |     |     |
| 38 Medically Necessary Transportation |  |  |  |  |  | 38 |
| 39 Ancillary Service Centers | 91,710 | 91,710 | 91,710 | 91,710 | 39 |
| 40 Barber and Beauty Shops |  |  |  |  |  | 40 |
| 41 Coffee and Gift Shops |  |  |  |  |  | 41 |
| 42 Provider Participation Fee | 49,275 | 49,275 | 49,275 | 49,275 | 42 |
| 43 Other (specify):* Non-allowable Costs | 28,285 | 699 | 262,114 | 291,098 | (291,098) | (291,098) | 43 |
| **TOTAL Special Cost Centers** | 28,285 | 92,409 | 311,389 | 432,083 | 432,083 | (291,098) | 140,985 | 44 |
| **GRAND TOTAL COST** (sum of lines 29, 37 & 44) | 1,809,715 | 412,390 | 2,119,071 | 4,341,176 | 4,341,176 | (467,251) | 3,873,925 | 45 |

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

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.)

<table>
<thead>
<tr>
<th>NON-ALLOWABLE EXPENSES</th>
<th>Amount</th>
<th>Reference</th>
<th>BHF USE ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Day Care</td>
<td>$</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2 Other Care for Outpatients</td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3 Governmental Sponsored Special Programs</td>
<td>(54)</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>4 Non-Patient Meals</td>
<td>(3,894)</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>5 Telephone, TV &amp; Radio in Resident Rooms</td>
<td>(14,309)</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>6 Rented Facility Space</td>
<td></td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>7 Sale of Supplies to Non-Patients</td>
<td></td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>8 Laundry for Non-Patients</td>
<td></td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>9 Non-Straightline Depreciation</td>
<td>(480)</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>10 Interest and Other Investment Income</td>
<td>(798)</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>11 Discounts, Allowances, Rebates &amp; Refunds</td>
<td></td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>12 Non-Working Officer's or Owner's Salary</td>
<td></td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>13 Sales Tax</td>
<td>(6)</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>14 Non-Care Related Interest</td>
<td></td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>15 Non-Care Related Owner's Transactions</td>
<td></td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>16 Personal Expenses (Including Transportation)</td>
<td></td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>17 Non-Care Related Fees</td>
<td></td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>18 Fines and Penalties</td>
<td>(604)</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>19 Entertainment</td>
<td></td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>20 Contributions</td>
<td></td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>21 Owner or Key-Man Insurance</td>
<td></td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>22 Special Legal Fees &amp; Legal Retainers</td>
<td></td>
<td>22</td>
<td></td>
</tr>
<tr>
<td>23 Malpractice Insurance for Individuals</td>
<td></td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>24 Bad Debt</td>
<td>(246,986)</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td>25 Fund Raising, Advertising and Promotional</td>
<td>(33,253)</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>26 Income Taxes and Illinois Personal Property Replacement Tax</td>
<td></td>
<td>26</td>
<td></td>
</tr>
<tr>
<td>27 CNA Training for Non-Employees</td>
<td></td>
<td>27</td>
<td></td>
</tr>
<tr>
<td>28 Yellow Page Advertising</td>
<td></td>
<td>28</td>
<td></td>
</tr>
<tr>
<td>29 Other-Attach Schedule See Page 5A</td>
<td>(14,309)</td>
<td>29</td>
<td></td>
</tr>
<tr>
<td>30 SUBTOTAL (A): (Sum of lines 1-29)</td>
<td>$ (300,384)</td>
<td>30</td>
<td></td>
</tr>
</tbody>
</table>

**BHF USE ONLY**

| 48 | 49 | 50 |

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below. (See instructions.)

<table>
<thead>
<tr>
<th>Amount</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>31</td>
<td>$</td>
</tr>
<tr>
<td>32</td>
<td>$</td>
</tr>
<tr>
<td>33</td>
<td>$</td>
</tr>
<tr>
<td>34</td>
<td>(166,867)</td>
</tr>
<tr>
<td>35</td>
<td>$</td>
</tr>
<tr>
<td>36</td>
<td>$ (166,867)</td>
</tr>
<tr>
<td>37</td>
<td>$ (467,251)</td>
</tr>
</tbody>
</table>

*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.)

<table>
<thead>
<tr>
<th>Amount</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>38</td>
<td>$</td>
</tr>
<tr>
<td>39</td>
<td>$</td>
</tr>
<tr>
<td>40</td>
<td>$</td>
</tr>
<tr>
<td>41</td>
<td>$</td>
</tr>
<tr>
<td>42</td>
<td>$</td>
</tr>
<tr>
<td>43</td>
<td>$</td>
</tr>
<tr>
<td>44</td>
<td>$</td>
</tr>
<tr>
<td>45</td>
<td>$</td>
</tr>
<tr>
<td>46</td>
<td>$</td>
</tr>
<tr>
<td>47</td>
<td>$</td>
</tr>
</tbody>
</table>

**TOTAL (C): (Sum of lines 38-46) $**
<table>
<thead>
<tr>
<th>Sch. V Line</th>
<th>NON-ALLOWABLE EXPENSES</th>
<th>Amount</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Labs-Part A</td>
<td>(8,134)</td>
<td>43 1</td>
</tr>
<tr>
<td>2</td>
<td>X-Rays-Part A</td>
<td>2,411</td>
<td>43 2</td>
</tr>
<tr>
<td>3</td>
<td>Offset Transportation Revenue</td>
<td>(8,970)</td>
<td>11 3</td>
</tr>
<tr>
<td>4</td>
<td>Offset Nursing Supplies Revenue</td>
<td>(1,810)</td>
<td>10 4</td>
</tr>
<tr>
<td>5</td>
<td>Offset Miscellaneous Office Supplies Revenue</td>
<td>(374)</td>
<td>21 5</td>
</tr>
<tr>
<td>6</td>
<td>Disallowed Special Events</td>
<td>(621)</td>
<td>43 6</td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td><strong>(14,309)</strong></td>
<td></td>
</tr>
</tbody>
</table>
## VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

<table>
<thead>
<tr>
<th>Name</th>
<th>Ownership %</th>
<th>Name</th>
<th>City</th>
<th>Type of Business</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mark B. Petersen</td>
<td>100%</td>
<td>See PG6 - Supp</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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  
- [x] 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.

### Schedule VI

<table>
<thead>
<tr>
<th>Line</th>
<th>V</th>
<th>Item</th>
<th>Amount</th>
<th>Name of Related Organization</th>
<th>Percent of Ownership</th>
<th>Operating Cost of Related Organization</th>
<th>Difference: Adjustments for Related Organization Costs (7 minus 4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>V</td>
<td>Dietary</td>
<td></td>
<td>Petersen Health Care, Inc.</td>
<td>100.00%</td>
<td>5,003</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>V</td>
<td>Food</td>
<td></td>
<td>Petersen Health Care, Inc.</td>
<td>100.00%</td>
<td>23</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>V</td>
<td>Housekeeping</td>
<td></td>
<td>Petersen Health Care, Inc.</td>
<td>100.00%</td>
<td>32</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>V</td>
<td>Laundry</td>
<td></td>
<td>Petersen Health Care, Inc.</td>
<td>100.00%</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>5</td>
<td>V</td>
<td>Utilities</td>
<td></td>
<td>Petersen Health Care, Inc.</td>
<td>100.00%</td>
<td>327</td>
<td>327</td>
</tr>
<tr>
<td>6</td>
<td>V</td>
<td>Maintenance</td>
<td></td>
<td>Petersen Health Care, Inc.</td>
<td>100.00%</td>
<td>2,040</td>
<td>2,040</td>
</tr>
<tr>
<td>7</td>
<td>V</td>
<td>Mgmt. Allocation of Benefits</td>
<td></td>
<td>Petersen Health Care, Inc.</td>
<td>100.00%</td>
<td>1,141</td>
<td>1,141</td>
</tr>
<tr>
<td>8</td>
<td>V</td>
<td>Nursing and Medical Records</td>
<td></td>
<td>Petersen Health Care, Inc.</td>
<td>100.00%</td>
<td>50</td>
<td>50</td>
</tr>
<tr>
<td>9</td>
<td>V</td>
<td>Therapy</td>
<td></td>
<td>Petersen Health Care, Inc.</td>
<td>100.00%</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>10</td>
<td>V</td>
<td>Mgmt. Allocation of Benefits</td>
<td></td>
<td>Petersen Health Care, Inc.</td>
<td>100.00%</td>
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<td>413,400</td>
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<td>95,000</td>
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<td>$ 413,400</td>
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* 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.  

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.

<table>
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<tr>
<th>Schedule V</th>
<th>Line</th>
<th>Item</th>
<th>Amount</th>
<th>Name of Related Organization</th>
<th>Percent of Ownership</th>
<th>Operating Cost of Related Organization</th>
<th>Difference: Adjustments for Related Organization Costs (7 minus 4)</th>
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</thead>
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<td>V 20</td>
<td>Dues, Fees, Subs &amp; Promotions</td>
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<td>34</td>
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<td>$ 87,569</td>
<td>* Total must agree with the amount recorded on line 34 of Schedule VI.</td>
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</tbody>
</table>

* 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.  

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.

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<thead>
<tr>
<th>Schedule V Line</th>
<th>Item Description</th>
<th>Amount</th>
<th>Name of Related Organization</th>
<th>Percent of Ownership</th>
<th>Operating Cost of Related Organization</th>
<th>Difference: Operating Cost of Related Organization of Related Organization</th>
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<td>15 V 1</td>
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<tr>
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<tr>
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<tr>
<td>29 V 23</td>
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<td></td>
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<tr>
<td>30 V 24</td>
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<tr>
<td>31 V 25</td>
<td>Other Admin. Staff Transport,</td>
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<td></td>
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<tr>
<td>32 V 26</td>
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<td>Petersen Health Operations, LLC</td>
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<tr>
<td>33 V 27</td>
<td>Mgmt. Allocation of Benefits</td>
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<td>100.00%</td>
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<td></td>
</tr>
<tr>
<td>34 V 30</td>
<td>Depreciation</td>
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<tr>
<td>37 V 34</td>
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<tr>
<td>38 V 35</td>
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* Total must agree with the amount recorded on line 34 of Schedule VI.
## VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

<table>
<thead>
<tr>
<th>1</th>
<th>OWNERS</th>
<th>Ownership %</th>
<th>2</th>
<th>RELATED NURSING HOMES</th>
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<th>OTHER RELATED BUSINESS ENTITIES</th>
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<tr>
<td></td>
<td>Name</td>
<td>City</td>
<td></td>
<td>Name</td>
<td>City</td>
<td>Type of Business</td>
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<td>Petersen Companies, L</td>
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<td>Mgmt/Bookkeeping</td>
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<td>3</td>
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<tr>
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<td>Lessor</td>
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<tr>
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</table>
### VII. RELATED PARTIES

#### A. (Continued)

Enter the names of ALL owners and related organizations (parties) as defined in the instructions.

<table>
<thead>
<tr>
<th>OWNERS</th>
<th>Ownership %</th>
<th>RELATED NURSING HOMES</th>
<th>CITY</th>
<th>OTHER RELATED BUSINESS ENTITIES</th>
<th>Type of Business</th>
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</thead>
<tbody>
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<td>Mason Point</td>
<td>Sullivan</td>
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VII. RELATED PARTIES

A. (Continued)  
Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

| 1 | OWNERS | Ownership % | 2 | RELATED NURSING HOMES | City | 3 | OTHER RELATED BUSINESS ENTITIES | Name | City | Type of Business |
|---|---|---|---|---|---|---|---|---|---|
| 1 | Toulon Health Care Center | Toulon |
| 2 | Tuscola Health Care Center | Tuscola |
| 3 | Twin Lakes Rehab & Health Care Center | Paris |
| 4 | Vandalia Rehab & Health Care Center | Vandalia |
| 5 | Watseka Health Care Center | Watseka |
| 6 | Westside Rehab & Care Center | West Frankfort |
| 7 | Whispering Oaks | Rosiclare |
| 8 | White Oak Rehab & Health Care Center | Mt. Vernon |
| 9 | Willow Rose Rehab & Health Care Center | Jerseyville |
| 10 | Sheldon Health Care Center | Sheldon |
| 11 | Tuscola Health Care Center | Tuscola |
| 12 | Effingham Health Care Center | Effingham |
| 13 | Collinsville Health Care Center | Collinsville |
| 14 | Ozark Rehab & Health Care Center | Osage Beach, MO |
| 15 | South Shore Health Care, LLC | Gary, IN |
| 16 | Cedargate Skilled Nursing Facility | Poplar Bluff, MO |
| 17 | Tarkin Rehab & Health Care Center | Tarkio, MO |
| 18 | Shangri-la Rehab & Living Center | Blue Springs, MO |
| 19 | Prairie Rose Care Center | Pana |
| 20 | Illini Heritage Rehab & Health Center | Champaign |
| 21 | Courtyard Estates of Kewanee | Kewanee |
| 22 | Courtyard Estates of Bradford | Bradford |
| 23 | Courtyard Estates of Galva | Galva |
| 24 | Courtyard Estates of Walcott | Walcott |
| 25 | Courtyard Village of Kewanee | Kewanee |
| 26 | Lakewood Village | Charleston |
| 27 | Courtyard Estates of Monmouth | Monmouth |
| 28 | Riverview Estates | Havana |
| 29 | Simple Blessings | Casey |
| 30 | Courtyard Estates of Bushnell | Bushnell |
### VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

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<th>OTHER RELATED BUSINESS ENTITIES</th>
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## 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.

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Function</th>
<th>Ownership Interest</th>
<th>Compensation Received From Other Nursing Homes*</th>
<th>Average Hours Per Work Week Devoted to this Facility and % of Total Work Week</th>
<th>Compensation Included in Costs for this Reporting Period**</th>
<th>Schedule V. Line &amp; Column Reference</th>
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* 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 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.**
### 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.

<table>
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<th>Schedule V Line Reference</th>
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<tr>
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<td>Unit of Allocation (i.e., Days, Direct Cost, Square Feet)</td>
<td>Total Units</td>
<td>Number of Subunits Being Allocated Among</td>
<td>Total Indirect Cost Being Allocated</td>
<td>Amount of Salary Cost Contained in Column 6</td>
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<td>Resident Days</td>
<td>1,542,131</td>
<td>77</td>
<td>266,518</td>
<td>0</td>
<td>24,799</td>
</tr>
<tr>
<td>18</td>
<td>26</td>
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<tr>
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<td>Resident Days</td>
<td>1,542,131</td>
<td>77</td>
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<td>21</td>
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<tr>
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<td>33</td>
<td>Real Estate Taxes</td>
<td>Resident Days</td>
<td>1,542,131</td>
<td>77</td>
<td>25,635</td>
<td>0</td>
<td>24,799</td>
</tr>
<tr>
<td>23</td>
<td>34</td>
<td>Rent-Facility and Grounds</td>
<td>Resident Days</td>
<td>1,542,131</td>
<td>77</td>
<td>0</td>
<td>0</td>
<td>24,799</td>
</tr>
<tr>
<td>24</td>
<td>35</td>
<td>Rent-Equipment &amp; Vehicles</td>
<td>Resident Days</td>
<td>1,542,131</td>
<td>77</td>
<td>45,440</td>
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</tr>
<tr>
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<td>$11,242,734</td>
<td>$7,781,943</td>
<td>$196,909</td>
<td>25</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### 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.

<table>
<thead>
<tr>
<th>Schedule V Line Reference</th>
<th>Item</th>
<th>Unit of Allocation (i.e., Days, Direct Cost, Square Feet)</th>
<th>Total Units</th>
<th>Number of Subunits Being Allocated Among</th>
<th>Total Indirect Cost Being Allocated</th>
<th>Amount of Salary Cost Contained in Column 6</th>
<th>Allocation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1 Dietary</td>
<td>Resident Days</td>
<td>402,040</td>
<td>21</td>
<td>$24,799</td>
<td>$49,624</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>2 Food</td>
<td>Resident Days</td>
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<td>21</td>
<td>$24,799</td>
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<tr>
<td>3</td>
<td>3 Housekeeping</td>
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<td>21</td>
<td>$24,799</td>
<td>$49,624</td>
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<tr>
<td>4</td>
<td>4 Laundry</td>
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<td>402,040</td>
<td>21</td>
<td>$24,799</td>
<td>$49,624</td>
<td>4</td>
</tr>
<tr>
<td>5</td>
<td>5 Utilities</td>
<td>Resident Days</td>
<td>402,040</td>
<td>21</td>
<td>$24,799</td>
<td>$49,624</td>
<td>5</td>
</tr>
<tr>
<td>6</td>
<td>6 Maintenance</td>
<td>Resident Days</td>
<td>402,040</td>
<td>21</td>
<td>$24,799</td>
<td>$49,624</td>
<td>6</td>
</tr>
<tr>
<td>7</td>
<td>7 Mgmt. Allocation of Benefits</td>
<td>Resident Days</td>
<td>402,040</td>
<td>21</td>
<td>$24,799</td>
<td>$49,624</td>
<td>7</td>
</tr>
<tr>
<td>8</td>
<td>10 Nursing and Medical Records</td>
<td>Resident Days</td>
<td>402,040</td>
<td>21</td>
<td>$24,799</td>
<td>$49,624</td>
<td>8</td>
</tr>
<tr>
<td>9</td>
<td>12 Social Services</td>
<td>Resident Days</td>
<td>402,040</td>
<td>21</td>
<td>$24,799</td>
<td>$49,624</td>
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<tr>
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<td>17 Administrative</td>
<td>Resident Days</td>
<td>402,040</td>
<td>21</td>
<td>$24,799</td>
<td>$49,624</td>
<td>10</td>
</tr>
<tr>
<td>11</td>
<td>19 Professional Services</td>
<td>Resident Days</td>
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<td>$19,096</td>
<td>$1,178</td>
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<tr>
<td>12</td>
<td>20 Dues, Fees, Subs &amp; Promotions</td>
<td>Resident Days</td>
<td>402,040</td>
<td>21</td>
<td>$24,799</td>
<td>$1,584</td>
<td>12</td>
</tr>
<tr>
<td>13</td>
<td>21 Clerical and General Office</td>
<td>Resident Days</td>
<td>402,040</td>
<td>21</td>
<td>$25,677</td>
<td>$1,584</td>
<td>13</td>
</tr>
<tr>
<td>14</td>
<td>22 Employee Benefits &amp; Payroll</td>
<td>Resident Days</td>
<td>402,040</td>
<td>21</td>
<td>$24,799</td>
<td>$1,584</td>
<td>14</td>
</tr>
<tr>
<td>15</td>
<td>23 Inservice Training &amp; Education</td>
<td>Resident Days</td>
<td>402,040</td>
<td>21</td>
<td>$24,799</td>
<td>$1,584</td>
<td>15</td>
</tr>
<tr>
<td>16</td>
<td>24 Travel and Seminar</td>
<td>Resident Days</td>
<td>402,040</td>
<td>21</td>
<td>$24,799</td>
<td>$1,584</td>
<td>16</td>
</tr>
<tr>
<td>17</td>
<td>25 Other Admin. Staff Transport.</td>
<td>Resident Days</td>
<td>402,040</td>
<td>21</td>
<td>$24,799</td>
<td>$1,584</td>
<td>17</td>
</tr>
<tr>
<td>18</td>
<td>26 Insurance-Prop./Liab./Malprac.</td>
<td>Resident Days</td>
<td>402,040</td>
<td>21</td>
<td>$24,799</td>
<td>$1,584</td>
<td>18</td>
</tr>
<tr>
<td>19</td>
<td>27 Mgmt. Allocation of Benefits</td>
<td>Resident Days</td>
<td>402,040</td>
<td>21</td>
<td>$24,799</td>
<td>$1,584</td>
<td>19</td>
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<tr>
<td>20</td>
<td>30 Depreciation</td>
<td>Resident Days</td>
<td>402,040</td>
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<td>$3,263</td>
<td>$201</td>
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<tr>
<td>21</td>
<td>32 Interest</td>
<td>Resident Days</td>
<td>402,040</td>
<td>21</td>
<td>$756,464</td>
<td>$46,661</td>
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</tr>
<tr>
<td>22</td>
<td>33 Real Estate Taxes</td>
<td>Resident Days</td>
<td>402,040</td>
<td>21</td>
<td>$24,799</td>
<td>$46,661</td>
<td>22</td>
</tr>
<tr>
<td>23</td>
<td>34 Rent-Facility and Grounds</td>
<td>Resident Days</td>
<td>402,040</td>
<td>21</td>
<td>$24,799</td>
<td>$46,661</td>
<td>23</td>
</tr>
<tr>
<td>24</td>
<td>35 Rent-Equipment &amp; Vehicles</td>
<td>Resident Days</td>
<td>402,040</td>
<td>21</td>
<td>$24,799</td>
<td>$46,661</td>
<td>24</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>804,500</strong></td>
<td><strong>$49,624</strong></td>
<td><strong>25</strong></td>
</tr>
</tbody>
</table>
**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

<table>
<thead>
<tr>
<th>Name of Lender</th>
<th>Related**</th>
<th>Purpose of Loan</th>
<th>Monthly Payment</th>
<th>Date of Note</th>
<th>Amount of Note</th>
<th>Maturity Date</th>
<th>Interest Rate</th>
<th>Reporting Period</th>
<th>Interest Expense</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>YES</td>
<td></td>
<td></td>
<td></td>
<td>Original</td>
<td>Balance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>NO</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**A. Directly Facility Related**

<table>
<thead>
<tr>
<th>Name of Lender</th>
<th>Related**</th>
<th>Purpose of Loan</th>
<th>Monthly Payment</th>
<th>Date of Note</th>
<th>Amount of Note</th>
<th>Maturity Date</th>
<th>Interest Rate</th>
<th>Reporting Period</th>
<th>Interest Expense</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>YES</td>
<td></td>
<td></td>
<td></td>
<td>Original</td>
<td>Balance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>NO</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Long-Term**

1. Bank of America X Mortgage Varies 1/19/07 $750,000 $710,267 12/31/13 Varies $37,721 1

2.

3. Interest Income Offset (798) 3

4. Home Office Allocation-PHC 8,066 4

5. Home Office Allocation-PHO 46,661 5

**Working Capital**

6.

7.

8.

9. TOTAL Facility Related

$750,000 $710,267 $91,650 9

**B. Non-Facility Related**

<table>
<thead>
<tr>
<th>Name of Lender</th>
<th>Related**</th>
<th>Purpose of Loan</th>
<th>Monthly Payment</th>
<th>Date of Note</th>
<th>Amount of Note</th>
<th>Maturity Date</th>
<th>Interest Rate</th>
<th>Reporting Period</th>
<th>Interest Expense</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>YES</td>
<td></td>
<td></td>
<td></td>
<td>Original</td>
<td>Balance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
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<td>NO</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

10.

11.

12.

13.

14. TOTAL Non-Facility Related

$ $ $ 14

15. TOTALS (line 9+line14)

$750,000 $710,267 $91,650 15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

*S 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.) HFS 3745 (N-4-99)
### IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

#### B. Real Estate Taxes

1. **Real Estate Tax accrual used on 2010 report.**
   - **Amount:** $36,300
   - **Line:** 1

2. **Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)**
   - **2010 Amount:** $37,519
   - **Line:** 2

3. **Under or (over) accrual (line 2 minus line 1).**
   - **Amount:** $1,219
   - **Line:** 3

4. **Real Estate Tax accrual used for 2011 report.  (Detail and explain your calculation of this accrual on the lines below.)**
   - **Amount:** $38,700
   - **Line:** 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.**
   - **Amount:** $5
   - **Line:** 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.**
   - **Total Refund For Tax Year:** $412
   - **Line:** 6

7. **Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.**
   - **Amount:** $40,331
   - **Line:** 7

**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**

**NOTES:**
1. Please indicate a negative number by use of brackets ( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.
2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME: South Elgin Rehabilitation & Health Care Center  COUNTY: Kane
FACILITY IDPH LICENSE NUMBER: 0047621
CONTACT PERSON REGARDING THIS REPORT: Mark Petersen
TELEPHONE: (309) 691-8113  FAX #: (309) 691-8622

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2010 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2010.

<table>
<thead>
<tr>
<th>(A)</th>
<th>(B)</th>
<th>(C)</th>
<th>(D) Tax Applicable to Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tax Index Number</td>
<td>Property Description</td>
<td>Total Tax</td>
<td></td>
</tr>
<tr>
<td>1. 06-34-226-014</td>
<td>Long-Term Care Facility</td>
<td>$37,518.74</td>
<td>$37,518.74</td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTALS</td>
<td></td>
<td>$37,518.74</td>
<td>$37,518.74</td>
</tr>
</tbody>
</table>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?  YES X NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home.

(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original second installment tax bill.
STATE OF ILLINOIS

Facility Name & ID Number: South Elgin Rehabilitation & Health Care Center # 0047621

Report Period
Beginning: 1/1/2011
Ending: 12/31/2011

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 15,169

B. General Construction Type: Exterior Brick, Frame, Wood

C. Does the Operating Entity? (a) Own the Facility, (b) Rent from a Related Organization, (c) Rent from Completely Unrelated Organization.

D. Does the Operating Entity? (a) Own the Equipment, (b) Rent equipment from a Related Organization, (c) Rent equipment from Completely Unrelated Organization.

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 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:

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Use</td>
<td>Square Feet</td>
<td>Year Acquired</td>
</tr>
<tr>
<td>1</td>
<td>Facility</td>
<td>131,116</td>
<td>2005</td>
</tr>
<tr>
<td>2</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>TOTALS</td>
<td>131,116</td>
<td></td>
</tr>
</tbody>
</table>

HFS 3745 (N-4-99) IL478-2471
B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

<table>
<thead>
<tr>
<th>Improvement Type**</th>
<th>Year Acquired</th>
<th>Cost</th>
<th>Life in Years</th>
<th>Depreciation</th>
<th>Accumulated Depreciation</th>
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</thead>
<tbody>
<tr>
<td>Wheelchair</td>
<td>2006</td>
<td>15,515</td>
<td>25</td>
<td>621</td>
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<td>Backflow Prevention</td>
<td>2006</td>
<td>14,325</td>
<td>25</td>
<td>573</td>
<td>573</td>
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<tr>
<td>Walls</td>
<td>2006</td>
<td>3,550</td>
<td>25</td>
<td>142</td>
<td>142</td>
</tr>
<tr>
<td>? Rooms-Floor Replacement, Painting, Wallpaper, Trim Labor</td>
<td>2007</td>
<td>10,400</td>
<td>20</td>
<td>520</td>
<td>520</td>
</tr>
<tr>
<td>? Rooms-Floor Tile, Sink, Supplies, Paint, Wallpaper</td>
<td>2007</td>
<td>5,100</td>
<td>20</td>
<td>255</td>
<td>255</td>
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<tr>
<td>Fire Sprinkler System Repair</td>
<td>2008</td>
<td>2,580</td>
<td>15</td>
<td>172</td>
<td>172</td>
</tr>
<tr>
<td>Dry Pipe Valve Accelerator Replacement</td>
<td>2008</td>
<td>8,436</td>
<td>15</td>
<td>562</td>
<td>562</td>
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<tr>
<td>Sprinkler System Repairs</td>
<td>2008</td>
<td>5,156</td>
<td>15</td>
<td>344</td>
<td>344</td>
</tr>
<tr>
<td>Water Line Repairs</td>
<td>2008</td>
<td>6,909</td>
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<tr>
<td>Sprinkler System Replacement</td>
<td>2009</td>
<td>27,836</td>
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<td>1,392</td>
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<td>Pendant Sprinkler System</td>
<td>2010</td>
<td>5,462</td>
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<td>Water Heater</td>
<td>2011</td>
<td>5,120</td>
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<td>366</td>
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</table>

**Note: 28 Facility was purchased as part of a multi-facility sale. For purposes of allocating the purchase price, appraisers valued the building and land at the value of the bare land only. The allocated amount appears on page 11 (Sch XI (A) line 1, column 4).

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

---

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

See Page 12A, Line 70 for total
**X. OWNERSHIP COSTS (continued)**

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

<table>
<thead>
<tr>
<th>Improvement Type**</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Year Constructed</td>
<td>Cost</td>
<td>Current Book Depreciation</td>
<td>Life in Years</td>
<td>Straight Line Depreciation</td>
<td>Adjustments</td>
<td>Accumulated Depreciation</td>
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<tr>
<td>60 Land Improvements Booked</td>
<td>$3,982</td>
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<td>$6,544</td>
<td>$1,012</td>
<td>$21,249</td>
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<td>65 2011-Home Office Allocation-Land Improvements</td>
<td>$11,803</td>
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<td>66 2011-Home Office Allocation-Building Improvements</td>
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</table>

**TOTAL (lines 4 thru 69) | $123,354 | $5,532 | $6,544 | $1,012 | $21,249 | $70 |

**Improvement type must be detailed in order for the cost report to be considered complete.
Facility Name & ID Number: South Elgin Rehabilitation & Health Care Center # 0047621  
State: Illinois  
Report Period Beginning: 1/1/2011  
Ending: 12/31/2011

### XI. OWNERSHIP COSTS (continued)

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

<table>
<thead>
<tr>
<th>Category of Equipment</th>
<th>1 Cost</th>
<th>Current Book Depreciation</th>
<th>2</th>
<th>Straight Line Depreciation</th>
<th>3</th>
<th>4 Adjustments</th>
<th>Component Life</th>
<th>5</th>
<th>Accumulated Depreciation</th>
<th>6</th>
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<tbody>
<tr>
<td>71 Purchased in Prior Years</td>
<td>$167,114</td>
<td>$22,713</td>
<td>$22,105</td>
<td>(608) 5-10 yrs.</td>
<td>$130,387</td>
<td>71</td>
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<tr>
<td>72 Current Year Purchases</td>
<td>9,286</td>
<td>995</td>
<td>464</td>
<td>(531) 10 yrs.</td>
<td>464</td>
<td>72</td>
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<tr>
<td>73 Fully Depreciated Assets</td>
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<tr>
<td>74 Home Office Allocation</td>
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<td>$6,549</td>
<td>74</td>
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<tr>
<td>75 TOTALS</td>
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#### D. Vehicle Costs. (See instructions.)*

<table>
<thead>
<tr>
<th>1 Use</th>
<th>Model, Make and Year</th>
<th>2 Year Acquired</th>
<th>3 Cost</th>
<th>4 Current Book Depreciation</th>
<th>5 Straight Line Depreciation</th>
<th>6 Adjustments</th>
<th>7 Life in Years</th>
<th>8 Accumulated Depreciation</th>
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<tbody>
<tr>
<td>76</td>
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<tr>
<td>77 N/A</td>
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</table>

#### E. Summary of Care-Related Assets

<table>
<thead>
<tr>
<th>1 Reference</th>
<th>2 Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>81 Total Historical Cost</td>
<td>(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)</td>
</tr>
<tr>
<td>82 Current Book Depreciation</td>
<td>(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)</td>
</tr>
<tr>
<td>83 Straight Line Depreciation</td>
<td>(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)</td>
</tr>
<tr>
<td>84 Adjustments</td>
<td>(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)</td>
</tr>
<tr>
<td>85 Accumulated Depreciation</td>
<td>(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)</td>
</tr>
</tbody>
</table>

#### F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

<table>
<thead>
<tr>
<th>1 Description &amp; Year Acquired</th>
<th>2 Cost</th>
<th>3 Current Book Depreciation</th>
<th>4 Accumulated Depreciation</th>
</tr>
</thead>
<tbody>
<tr>
<td>86</td>
<td>$</td>
<td>$</td>
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<td>87</td>
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<td></td>
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<tr>
<td>88 N/A</td>
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<td>89</td>
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<td></td>
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<td>90</td>
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<tr>
<td>91 TOTALS</td>
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</tbody>
</table>

#### G. Construction-in-Progress

<table>
<thead>
<tr>
<th>1 Description</th>
<th>2 Cost</th>
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</thead>
<tbody>
<tr>
<td>92</td>
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<tr>
<td>93 N/A</td>
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<td>94</td>
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<tr>
<td>95</td>
<td>$</td>
</tr>
</tbody>
</table>

* 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

<p>| | | | | | |</p>
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Year</td>
<td>2</td>
<td>Number # of Beds</td>
<td>3</td>
<td>Original Lease Date</td>
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<td>TOTAL</td>
<td>7</td>
<td>$</td>
<td>7</td>
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</tbody>
</table>

10. Effective dates of current rental agreement:
   Beginning
   Ending

11. Rent to be paid in future years under the current rental agreement:

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<tr>
<th>Fiscal Year Ending</th>
<th>Annual Rent</th>
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<td>2012</td>
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<tr>
<td>2013</td>
<td>$</td>
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<tr>
<td>2014</td>
<td>$</td>
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</tbody>
</table>

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: $12,113 Description: See Attached Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

<p>| | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Use</td>
<td>2</td>
<td>Model Year</td>
<td>3</td>
<td>Monthly Lease Payment</td>
</tr>
<tr>
<td>---</td>
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<td>---</td>
<td>---------</td>
<td>---</td>
<td>----------------</td>
</tr>
<tr>
<td>17 Facility</td>
<td>2006 Ford E250</td>
<td>$</td>
<td>578.17</td>
<td>$</td>
<td>6,938</td>
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<td></td>
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<td>20</td>
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<tr>
<td>TOTAL</td>
<td>$</td>
<td>578.17</td>
<td>$</td>
<td>6,938</td>
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</tr>
</tbody>
</table>

* 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.
South Elgin Rehabilitation & Health Care Center
0047621

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

Schedule 14A

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

<table>
<thead>
<tr>
<th>Equipment</th>
<th>Amount</th>
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<tbody>
<tr>
<td>Medical Equipment</td>
<td>$4,212</td>
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<tr>
<td>Dishwasher</td>
<td>$708</td>
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<tr>
<td>Laundry Equipment</td>
<td>-</td>
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<tr>
<td>Copier</td>
<td>$6,462</td>
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<td>Home Office Allocation</td>
<td>$731</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>$12,113</strong></td>
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</tbody>
</table>

HFS 3745 (N-4-99)
### A. TYPE OF TRAINING PROGRAM

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

It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

#### 1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

- [ ] NO
- [X] IN-HOUSE PROGRAM
- [ ] IN OTHER FACILITY
- [ ] COMMUNITY COLLEGE

#### 2. CLASSROOM PORTION:

- [X] IN-HOUSE PROGRAM
- [ ] IN OTHER FACILITY
- [ ] COMMUNITY COLLEGE

#### 3. CLINICAL PORTION:

- [X] IN-HOUSE PROGRAM
- [ ] IN OTHER FACILITY
- [ ] COMMUNITY COLLEGE

### B. EXPENSES

#### ALLOCATION OF COSTS

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<td>Community College Tuition</td>
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</tr>
<tr>
<td>Books and Supplies</td>
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<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Classroom Wages (a)</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Clinical Wages (b)</td>
<td>$</td>
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<td>$</td>
</tr>
<tr>
<td>In-House Trainer Wages (c)</td>
<td>$</td>
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</tr>
<tr>
<td>Transportation</td>
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<td>Contractual Payments</td>
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<table>
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<tr>
<td>Transportation</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Contractual Payments</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>CNA Competency Tests</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>TOTALS</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

(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.

### 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

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>COMPLETED</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. From this facility</td>
<td>DROP-OUTS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. From other facilities (f)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DROP-OUTS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. From this facility</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. From other facilities (f)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(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.)

<table>
<thead>
<tr>
<th>Service</th>
<th>Schedule V Line &amp; Column Reference</th>
<th>Staff</th>
<th>Cost</th>
<th>Outside Practitioner (other than consultant)</th>
<th>Supplies (Actual or Allocated)</th>
<th>Total Units (Column 2 + 4)</th>
<th>Total Cost (Col. 3 + 5 + 6)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Licensed Occupational Therapist</td>
<td>10A(3)</td>
<td>hrs</td>
<td>$21,532</td>
<td>$322,974</td>
<td></td>
<td>21,532</td>
<td>322,974</td>
</tr>
<tr>
<td>2 Licensed Speech and Language Development Therapist</td>
<td>10A(3)</td>
<td>hrs</td>
<td>6,385</td>
<td>95,776</td>
<td></td>
<td>6,385</td>
<td>95,776</td>
</tr>
<tr>
<td>3 Licensed Recreational Therapist</td>
<td>hrs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Licensed Physical Therapist</td>
<td>10A(2), 10A(3)</td>
<td>hrs</td>
<td>30,188</td>
<td>452,822</td>
<td>48</td>
<td>30,188</td>
<td>452,870</td>
</tr>
<tr>
<td>5 Physician Care</td>
<td>visits</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Dental Care</td>
<td>visits</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 Work Related Program</td>
<td>hrs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 Habilitation</td>
<td>hrs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 Pharmacy</td>
<td>39(2)</td>
<td># of prescrips</td>
<td>91,710</td>
<td>91,710</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 Psychological Services (Evaluation and Diagnosis/ Behavior Modification)</td>
<td>hrs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11 Academic Education</td>
<td>hrs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 Other (specify):</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13 Other (specify): Respiratory Therapy</td>
<td>10A(3)</td>
<td>hrs</td>
<td>29</td>
<td>440</td>
<td></td>
<td>29</td>
<td>440</td>
</tr>
<tr>
<td>14 TOTAL</td>
<td></td>
<td></td>
<td>58,134</td>
<td>872,012</td>
<td>91,758</td>
<td>58,134</td>
<td>963,770</td>
</tr>
</tbody>
</table>

**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.
<table>
<thead>
<tr>
<th>Facility Name &amp; ID Number</th>
<th>State of Illinois</th>
<th>Report Period Beginning:</th>
<th>Ending:</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Elgin Rehabilitation &amp; Health Care Center # 0047621</td>
<td>1/1/2011</td>
<td>12/31/2011</td>
<td></td>
</tr>
</tbody>
</table>

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

This report must be completed even if financial statements are attached.

### A. Current Assets

<table>
<thead>
<tr>
<th>1</th>
<th>Operating</th>
<th>2</th>
<th>After</th>
<th>Consolidation*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Cash on Hand and in Banks</td>
<td>$ 1,656,266</td>
<td>$ 1,656,266</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>Cash-Patient Deposits</td>
<td>$ 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Accounts &amp; Short-Term Notes Receivable- Patients (less allowance 260,000)</td>
<td>$ 1,940,068</td>
<td>$ 1,940,068</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>Supply Inventory (priced at )</td>
<td>$ 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Short-Term Investments</td>
<td>$ 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Prepaid Insurance</td>
<td>25,125</td>
<td>25,125</td>
<td>6</td>
</tr>
<tr>
<td>7</td>
<td>Other Prepaid Expenses</td>
<td>12,521</td>
<td>12,521</td>
<td>7</td>
</tr>
<tr>
<td>8</td>
<td>Accounts Receivable (owners or related parties)</td>
<td>$ 1,576</td>
<td>$ 1,576</td>
<td>8</td>
</tr>
<tr>
<td>9</td>
<td>Other(specify): Other Prepaid Expenses</td>
<td>$ 1,576</td>
<td>$ 1,576</td>
<td>9</td>
</tr>
<tr>
<td><strong>10</strong></td>
<td>TOTAL Current Assets (sum of lines 1 thru 9)</td>
<td>$ 3,635,556</td>
<td>$ 3,635,556</td>
<td>10</td>
</tr>
</tbody>
</table>

### B. Long-Term Assets

| 11 | Long-Term Notes Receivable | $ 11 |
| 12 | Long-Term Investments | $ 12 |
| 13 | Land | 467,500 | 13 |
| 14 | Buildings, at Historical Cost | 467,500 | 11,803 | 14 |
| 15 | Leasehold Improvements, at Historical Cost | 98,324 | 111,551 | 15 |
| 16 | Equipment, at Historical Cost | 176,400 | 176,400 | 16 |
| 17 | Accumulated Depreciation (book methods) (166,085) (152,100) | 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) | $ 576,139 | $ 615,154 | 24 |
| **25** | TOTAL ASSETS (sum of lines 10 and 24) | $ 4,211,695 | $ 4,250,710 | 25 |

### C. Current Liabilities

| 26 | Accounts Payable | $ 813,743 | $ 813,743 | 26 |
| 27 | Officer's Accounts Payable | 27 |
| 28 | Accounts Payable-Patient Deposits | 28 |
| 29 | Short-Term Notes Payable | 29 |
| 30 | Accrued Salaries Payable | $ 36,686 | $ 36,686 | 30 |
| 31 | Accrued Taxes Payable (excluding real estate taxes) | 5,537 | 5,537 | 31 |
| 32 | Accrued Real Estate Taxes(Sch.IX-B) | 38,700 | 38,700 | 32 |
| 33 | Accrued Interest Payable | 3,718 | 3,718 | 33 |
| 34 | Deferred Compensation | 34 |
| 35 | Federal and State Income Taxes | 35 |
| 36 | Payroll Withholdings | 41,792 | 41,792 | 36 |
| **37** | TOTAL Current Liabilities (sum of lines 26 thru 37) | $ 940,176 | $ 940,176 | 37 |

### D. Long-Term Liabilities

| 38 | TOTAL Long-Term Liabilities (sum of lines 45 thru 44) | $ 710,267 | $ 710,267 | 38 |
| 39 | Long-Term Notes Payable | 39 |
| 40 | Mortgage Payable | 710,267 | 710,267 | 40 |
| 41 | Bonds Payable | 41 |
| 42 | Deferred Compensation | 42 |
| **43** | TOTAL Long-Term Liabilities (sum of lines 39 thru 45) | $ 1,650,443 | $ 1,650,443 | 43 |
| **44** | TOTAL LIABILITIES (sum of lines 38 and 45) | $ 1,650,443 | $ 1,650,443 | 44 |
| **45** | TOTAL EQUITY(page 18, line 24) | $ 2,561,252 | $ 2,600,267 | 45 |
| **46** | TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47) | $ 4,211,695 | $ 4,250,710 | 46 |

*(See instructions.)*
**STATE OF ILLINOIS**

Facility Name & ID Number: South Elgin Rehabilitation & Health Care Center # 0047621


### XVI. STATEMENT OF CHANGES IN EQUITY

<table>
<thead>
<tr>
<th></th>
<th>1. Balance at Beginning of Year, as Previously Reported</th>
<th>$ 1,770,726</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Restatements (describe):</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Balance at Beginning of Year, as Restated (sum of lines 1-5)</td>
<td>$ 1,770,726</td>
</tr>
</tbody>
</table>

**A. Additions (deductions):**

<table>
<thead>
<tr>
<th></th>
<th>7. NET Income (Loss) (from page 19, line 43)</th>
<th>$ 790,526</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>8. Acquisitions of Pooled Companies</td>
<td></td>
</tr>
<tr>
<td></td>
<td>9. Proceeds from Sale of Stock</td>
<td></td>
</tr>
<tr>
<td></td>
<td>10. Stock Options Exercised</td>
<td></td>
</tr>
<tr>
<td></td>
<td>11. Contributions and Grants</td>
<td></td>
</tr>
<tr>
<td></td>
<td>12. Expenditures for Specific Purposes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>13. Dividends Paid or Other Distributions to Owners</td>
<td>( )</td>
</tr>
<tr>
<td></td>
<td>14. Donated Property, Plant, and Equipment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>15. Other (describe)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>16. Other (describe)</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>TOTAL Additions (deductions) (sum of lines 7-16)</td>
<td>$ 790,526</td>
</tr>
</tbody>
</table>

**B. Transfers (Itemize):**

|   | 18.                                           |             |
|   | 19.                                           |             |
|   | 20.                                           |             |
|   | 21.                                           |             |
|   | 22.                                           |             |
| 23 | TOTAL Transfers (sum of lines 18-22)          | $ 2,561,252 |
| 24 | BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23) | $ 2,561,252 |

* This must agree with page 17, line 47.
**STATE OF ILLINOIS**

Facility Name & ID Number  South Elgin Rehabilitation & Health Care Center # 0047621 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

---

### XVII. INCOME STATEMENT

(attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note:** This schedule should show gross revenue and expenses. Do not net revenue against expense.

**1. Revenue**

<table>
<thead>
<tr>
<th>Revenue</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Inpatient Care</td>
<td></td>
</tr>
<tr>
<td>1 Gross Revenue -- All Levels of Care $</td>
<td>3,835,489</td>
</tr>
<tr>
<td>2 Discounts and Allowances for all Levels (35,918)</td>
<td>2</td>
</tr>
<tr>
<td>3 SUBTOTAL Inpatient Care (line 1 minus line 2) $</td>
<td>3,799,571</td>
</tr>
<tr>
<td>B. Ancillary Revenue</td>
<td></td>
</tr>
<tr>
<td>4 Day Care</td>
<td>4</td>
</tr>
<tr>
<td>5 Other Care for Outpatients</td>
<td>5</td>
</tr>
<tr>
<td>6 Therapy</td>
<td>1,159,677</td>
</tr>
<tr>
<td>7 Oxygen</td>
<td>973</td>
</tr>
<tr>
<td>8 SUBTOTAL Ancillary Revenue (lines 4 thru 7) $</td>
<td>1,160,650</td>
</tr>
<tr>
<td>C. Other Operating Revenue</td>
<td></td>
</tr>
<tr>
<td>9 Payments for Education</td>
<td>9</td>
</tr>
<tr>
<td>10 Other Government Grants</td>
<td>10</td>
</tr>
<tr>
<td>11 CNA Training Reimbursements</td>
<td>11</td>
</tr>
<tr>
<td>12 Gift and Coffee Shop</td>
<td>12</td>
</tr>
<tr>
<td>13 Barber and Beauty Care</td>
<td>13</td>
</tr>
<tr>
<td>14 Non-Patient Meals</td>
<td>54</td>
</tr>
<tr>
<td>15 Telephone, Television and Radio</td>
<td>15</td>
</tr>
<tr>
<td>16 Rental of Facility Space</td>
<td>16</td>
</tr>
<tr>
<td>17 Sale of Drugs</td>
<td>145,917</td>
</tr>
<tr>
<td>18 Sale of Supplies to Non-Patients</td>
<td>18</td>
</tr>
<tr>
<td>19 Laboratory</td>
<td>19</td>
</tr>
<tr>
<td>20 Radiology and X-Ray</td>
<td>13,338</td>
</tr>
<tr>
<td>21 Other Medical Services</td>
<td>3,420</td>
</tr>
<tr>
<td>22 Laundry</td>
<td>22</td>
</tr>
<tr>
<td>23 SUBTOTAL Other Operating Revenue (lines 9 thru 22) $</td>
<td>162,729</td>
</tr>
<tr>
<td>D. Non-Operating Revenue</td>
<td></td>
</tr>
<tr>
<td>24 Contributions</td>
<td>24</td>
</tr>
<tr>
<td>25 Interest and Other Investment Income***</td>
<td>798</td>
</tr>
<tr>
<td>26 SUBTOTAL Non-Operating Revenue (lines 24 and 25) $</td>
<td>798</td>
</tr>
<tr>
<td>E. Other Revenue (specify):****</td>
<td></td>
</tr>
<tr>
<td>27 Settlement Income (Insurance, Legal, Etc.)</td>
<td>27</td>
</tr>
<tr>
<td>28 Miscellaneous Revenue</td>
<td>1,984</td>
</tr>
<tr>
<td>29a Transportation Revenue</td>
<td>5,970</td>
</tr>
<tr>
<td>29 SUBTOTAL Other Revenue (lines 27, 28 and 29a) $</td>
<td>7,954</td>
</tr>
<tr>
<td>30 TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29) $</td>
<td>5,131,702</td>
</tr>
</tbody>
</table>

---

### Expenses

<table>
<thead>
<tr>
<th>Expenses</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Operating Expenses</td>
<td></td>
</tr>
<tr>
<td>31 General Services</td>
<td>611,950</td>
</tr>
<tr>
<td>32 Health Care</td>
<td>2,445,483</td>
</tr>
<tr>
<td>33 General Administration</td>
<td>720,460</td>
</tr>
<tr>
<td>B. Capital Expense</td>
<td></td>
</tr>
<tr>
<td>34 Ownership</td>
<td>125,200</td>
</tr>
<tr>
<td>C. Ancillary Expense</td>
<td></td>
</tr>
<tr>
<td>35 Special Cost Centers</td>
<td>382,800</td>
</tr>
<tr>
<td>36 Provider Participation Fee</td>
<td>49,275</td>
</tr>
<tr>
<td>D. Other Expenses (specify):</td>
<td></td>
</tr>
<tr>
<td>37</td>
<td></td>
</tr>
<tr>
<td>38</td>
<td></td>
</tr>
<tr>
<td>39</td>
<td></td>
</tr>
<tr>
<td>40 TOTAL EXPENSES (sum of lines 31 thru 39)*</td>
<td>$ 4,341,176</td>
</tr>
<tr>
<td>41 Income before Income Taxes (line 30 minus line 40)**</td>
<td>790,526</td>
</tr>
<tr>
<td>42 Income Taxes</td>
<td>42</td>
</tr>
<tr>
<td>43 NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42) $</td>
<td>790,526</td>
</tr>
</tbody>
</table>

---

* 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**  
South Elgin Rehabilitation & Health Care Center # 0047621

**Report Period**  
Beginning: 1/1/2011  
Ending: 12/31/2011

### XVIII. STAFFING AND SALARY COSTS

Please report each line separately. This schedule must cover the entire reporting period.

<table>
<thead>
<tr>
<th>#</th>
<th>Name</th>
<th># of Hrs. Actually Worked</th>
<th># of Hrs. Paid and Accrued</th>
<th>Reporting Period Total Salaries, Wages</th>
<th>Average Hourly Wage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Director of Nursing</td>
<td>2,228</td>
<td>2,228</td>
<td>71,069</td>
<td>$31.90</td>
</tr>
<tr>
<td>2</td>
<td>Assistant Director of Nursing</td>
<td>1,733</td>
<td>1,733</td>
<td>50,827</td>
<td>29.33</td>
</tr>
<tr>
<td>3</td>
<td>Registered Nurses</td>
<td>14,607</td>
<td>15,180</td>
<td>478,907</td>
<td>31.55</td>
</tr>
<tr>
<td>4</td>
<td>Licensed Practical Nurses</td>
<td>5,659</td>
<td>5,741</td>
<td>148,935</td>
<td>25.94</td>
</tr>
<tr>
<td>5</td>
<td>CNAs &amp; Orderlies</td>
<td>41,781</td>
<td>42,798</td>
<td>483,002</td>
<td>11.29</td>
</tr>
<tr>
<td>6</td>
<td>CNA Trainees</td>
<td>39</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Licensed Therapist</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Rehab/Therapy Aides</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Activity Director</td>
<td>1,877</td>
<td>1,877</td>
<td>25,424</td>
<td>13.55</td>
</tr>
<tr>
<td>10</td>
<td>Activity Assistants</td>
<td>1,177</td>
<td>1,177</td>
<td>9,568</td>
<td>8.13</td>
</tr>
<tr>
<td>11</td>
<td>Social Service Workers</td>
<td>2,080</td>
<td>2,080</td>
<td>39,160</td>
<td>18.83</td>
</tr>
<tr>
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<td>10,448</td>
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<td>28</td>
<td>Qualified MR Prof. (QMRP)</td>
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<td>29</td>
<td>Resident Services Coordinator</td>
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<td>30</td>
<td>Habilitation Aides (DD Homes)</td>
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<td>31</td>
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<td>36,810</td>
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<td>32</td>
<td>Other Health Care Plan Coord.</td>
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<td>75,074</td>
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<td>33</td>
<td>Other(specify) Marketing</td>
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**B. CONSULTANT SERVICES**

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<th>#</th>
<th>Name</th>
<th>Number of Hrs. Paid and Accrued</th>
<th>Total Consultant Cost for Reporting Period</th>
<th>Schedule V Line &amp; Column Reference</th>
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<tbody>
<tr>
<td>35</td>
<td>Dietary Consultant</td>
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<td>36</td>
<td>Medical Director</td>
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<td>14,400</td>
<td>L9, C3</td>
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<td>37</td>
<td>Medical Records Consultant</td>
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<td>38</td>
<td>Nurse Consultant</td>
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<tr>
<td>39</td>
<td>Pharmacist Consultant</td>
<td>Monthly</td>
<td>4,505</td>
<td>L10, C3</td>
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<td>40</td>
<td>Physical Therapy Consultant</td>
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<td>41</td>
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<td>43</td>
<td>Speech Therapy Consultant</td>
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<td>Activity Consultant</td>
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<td>Social Service Consultant</td>
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<td>46</td>
<td>Other(specify)</td>
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<td>48</td>
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<td>49</td>
<td>TOTAL (lines 35 - 48)</td>
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**C. CONTRACT NURSES**

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<th>#</th>
<th>Name</th>
<th>Number of Hrs. Paid and Accrued</th>
<th>Total Contract Wages</th>
<th>Schedule V Line &amp; Column Reference</th>
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<tbody>
<tr>
<td>50</td>
<td>Registered Nurses</td>
<td>135</td>
<td>4,412</td>
<td>L10, C3</td>
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<tr>
<td>51</td>
<td>Licensed Practical Nurses</td>
<td>202</td>
<td>6,744</td>
<td>L10, C3</td>
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<td>52</td>
<td>Certified Nurse Assistants/Aides</td>
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<td>53</td>
<td>TOTAL (lines 50 - 52)</td>
<td>337</td>
<td>11,156</td>
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**Notes:**  
* This total must agree with page 4, column 1, line 45.  
** See instructions.
**XIX. SUPPORT SCHEDULES**

### A. Administrative Salaries

<table>
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<tr>
<th>Name</th>
<th>Function</th>
<th>%</th>
<th>Amount</th>
<th>Description</th>
<th>Amount</th>
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</thead>
<tbody>
<tr>
<td>Mary Karson</td>
<td>Administrator</td>
<td>0</td>
<td>$95,000</td>
<td>Workers' Compensation Insurance</td>
<td>$30,645</td>
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<td>Unemployment Compensation Insurance</td>
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<td>FICA Taxes</td>
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<td>Employee Health Insurance</td>
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<td>Employee Meals</td>
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<td>Illinois Municipal Retirement Fund (IMRF)*</td>
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<td>Employee Relations</td>
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<td>Employee Retirement</td>
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<td>Life Insurance</td>
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<tr>
<td><strong>TOTAL</strong> (agree to Schedule V, line 17, col. 1)</td>
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<td>$95,000</td>
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</tbody>
</table>

### B. Administrative - Other

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
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<tbody>
<tr>
<td>Management Fees-See Page 6, Eliminated on P 3, C 7</td>
<td>$413,400</td>
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</table>

**TOTAL (agree to Schedule V, line 17, col. 3) $413,400**

### C. Professional Services

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<tr>
<th>Vendor/Payee</th>
<th>Type</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>E-Health Data Solutions</td>
<td>Computer Services</td>
<td>$3,485</td>
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<td>AT&amp;T</td>
<td>Computer Services</td>
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<td>Ngo, Westfall, Gryska</td>
<td>Legal Services</td>
<td>$368</td>
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<td>McHenry Co. Circuit Clerk</td>
<td>Legal Services</td>
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<td>Comcast Cable</td>
<td>Computer Services</td>
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<tr>
<td>Honkamp Kruger &amp; Co.</td>
<td>Accounting Fees</td>
<td>$280</td>
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</table>

**TOTAL (agree to Schedule V, line 19, column 3) $4,955**

*Attach copy of IMRF notifications*

### F. Dues, Fees, Subscriptions and Promotions

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
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<tbody>
<tr>
<td>IDPH License Fee</td>
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<td>Patient Background Checks</td>
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<td>Miscellaneous Licenses &amp; Permits</td>
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<tr>
<td>Miscellaneous Dues &amp; Subscriptions</td>
<td>$0</td>
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<td>Life Insurance</td>
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<td>Home Office Allocation</td>
<td>$402</td>
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</table>

**TOTAL (agree to Schedule V, line 20, col. 8) $3,942**

**TOTAL (agree to Schedule V, line 22, col. 8) $223,839**

### G. Schedule of Travel and Seminar**

<table>
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<th>Description</th>
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<td>Out-of-State Travel</td>
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<tr>
<td>In-State Travel</td>
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<td>Seminar Expense</td>
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<td>Home Office Allocation</td>
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<tr>
<td>Entertainment Expense</td>
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**TOTAL (agree to Sch. V, line 24, col. 8) $49**

**See instructions.**
XIX. SUPPORT SCHEDULE
C. Professional Services

<table>
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<tr>
<th>Vendor/Payee</th>
<th>Type</th>
<th>Amount</th>
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<tbody>
<tr>
<td>Total (agree to Schedule V, line 19, column 3)</td>
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<td>4,955</td>
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Home Office Allocation

<table>
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<th>Vendor/Payee</th>
<th>Type</th>
<th>Amount</th>
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<tr>
<td>Heyl, Royster, Voelker &amp; Allen</td>
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<td>Henry County Recorder</td>
<td>Legal</td>
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<tr>
<td>Ginoli &amp; Company</td>
<td>Accountants</td>
<td>1,973</td>
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<tr>
<td>Miscellaneous Vendors</td>
<td>Computer Services</td>
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<tr>
<td>Advanced Answers on Demand</td>
<td>Computer Services</td>
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<td>Access 2 Go</td>
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<td>Kemper Technology</td>
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<td>MediFax</td>
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<td>VisionShare</td>
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<td>Advanced System Design</td>
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<td>Simple LTC</td>
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<td>Optimizer Systems</td>
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<td>Clifton Gunderson</td>
<td>Other Prof Fees</td>
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<td>Mike Miller</td>
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<td>OIC Group</td>
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<td>All Scripts</td>
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Total (agree to Schedule V, line 19, column 8)  11,857
### XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS

(See instructions.)

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<th>FY2009</th>
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<th>FY2011</th>
<th>FY2012</th>
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**(See instructions)**
## Facility Name & ID Number
South Elgin Rehabilitation & Health Care Center

### 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? | N/A |
| What was the average life used for new equipment added during this period? | 10 yrs |
| (5) Have you properly capitalized all major repairs and equipment purchases? | Yes |
| (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. | $32,276 | Line 10 |
| (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? | Yes |
| If NO, attach a complete explanation. |
| (8) Are you presently operating under a sale and leaseback arrangement? | No |
| If YES, give effective date of lease. |  |
| (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 | X | NO |
| IdPH license number of this related party and the date the present owners took over. |  |
| (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. | $49,275 |
| This amount is to be recorded on line 42 of Schedule V. |
| (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? | No |
| If YES, attach an explanation of the allocation. |
| (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? | Yes |
| (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? | N/A |
| For example, is a portion of the building used for rental, a pharmacy, day care, etc.? If YES, attach a schedule which explains how all related costs were allocated to these functions. |  |
| (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. | $0 |
| Has any meal income been offset against related costs? | Yes |
| Indicate the amount. | $54 |
| (16) Travel and Transportation |
| a. Are there costs included for out-of-state travel? | No |
| If YES, attach a complete explanation. |
| b. Do you have a separate contract with the Department to provide medical transportation for residents? | Yes |
| If YES, please indicate the amount of income earned from such a program during this reporting period. | $312 |
| c. What percent of all travel expense relates to transportation of nurses and patients? | N/A |
| d. Have vehicle usage logs been maintained? | Adequate records have been maintained. |
| e. Are all vehicles stored at the nursing home during the night and all other times when not in use? | Yes |
| f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? | N/A |
| g. Does the facility transport residents to and from day training? | N/A |
| Indicate the amount of income earned from providing such transportation during this reporting period. | $N/A |
| (17) Has an audit been performed by an independent certified public accounting firm? | Yes |
| Firm Name: | Ginoli & Company |
| (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? | Yes |
| (19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? | N/A |
| Attach invoices and a summary of services for all architect and appraisal fees |  |