

Facility Name & ID Number Arcola Health Care Center

0046045 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	50	Skilled (SNF)	50	18,250	1
2		Skilled Pediatric (SNF/PED)			2
3	50	Intermediate (ICF)	50	18,250	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	100	TOTALS	100	36,500	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF			1,103	1,103	8
9	SNF/PED					9
10	ICF	24,891	2,498	378	27,767	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,891	2,498	1,481	28,870	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.10%

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

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

I. On what date did you start providing long term care at this location?

Date started 11/9/1993

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

YES Date 11/9/1993 NO

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

YES NO If YES, enter number of beds certified 50 and days of care provided 1,103

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL 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.

Facility Name & ID Number Arcola Health Care Center # 0046045 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 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
	A. General Services										
1	Dietary	144,654	18,957		163,611		163,611	5,049	168,660		1
2	Food Purchase		138,489		138,489		138,489	(4,315)	134,174		2
3	Housekeeping	97,994	18,442		116,436		116,436	48	116,484		3
4	Laundry	56,978	8,646		65,624		65,624		65,624		4
5	Heat and Other Utilities			97,057	97,057		97,057	498	97,555		5
6	Maintenance	27,949	9,497	21,382	58,828		58,828	2,445	61,273		6
7	Other (specify):* <u>Home Off. Ben. All.</u>							912	912		7
8	TOTAL General Services	327,575	194,031	118,439	640,045		640,045	4,637	644,682		8
	B. Health Care and Programs										
9	Medical Director			34,800	34,800		34,800		34,800		9
10	Nursing and Medical Records	793,912	67,811	134,248	995,971		995,971	3,036	999,007		10
10a	Therapy		277	125,148	125,425		125,425		125,425		10a
11	Activities	53,138	673	74	53,885		53,885	(194)	53,691		11
12	Social Services	63,145	50		63,195		63,195		63,195		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Off. Ben. All.</u>							376	376		15
16	TOTAL Health Care and Programs	910,195	68,811	294,270	1,273,276		1,273,276	3,218	1,276,494		16
	C. General Administration										
17	Administrative	16,250			16,250		16,250	53,426	69,676		17
18	Directors Fees										18
19	Professional Services			5,197	5,197		5,197	7,079	12,276		19
20	Dues, Fees, Subscriptions & Promotions			6,170	6,170		6,170	1,973	8,143		20
21	Clerical & General Office Expenses	9,273	5,230	7,311	21,814		21,814	51,395	73,209		21
22	Employee Benefits & Payroll Taxes			188,968	188,968		188,968		188,968		22
23	Inservice Training & Education			159	159		159	525	684		23
24	Travel and Seminar							162	162		24
25	Other Admin. Staff Transportation			7,193	7,193		7,193	2,537	9,730		25
26	Insurance-Prop.Liab.Malpractice			33,240	33,240		33,240	1,052	34,292		26
27	Other (specify):* <u>Home Off. Ben. All.</u>							13,819	13,819		27
28	TOTAL General Administration	25,523	5,230	248,238	278,991		278,991	131,968	410,959		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,263,293	268,072	660,947	2,192,312		2,192,312	139,823	2,332,135		29

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

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

Facility Name & ID Number Arcola Health Care Center

#0046045

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			45,795	45,795		45,795	17,988	63,783			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			150,214	150,214		150,214	6,380	156,594			32
33	Real Estate Taxes			26,453	26,453		26,453	639	27,092			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			8,166	8,166		8,166	612	8,778			35
36	Other (specify):*											36
37	TOTAL Ownership			230,628	230,628		230,628	25,619	256,247			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		57,940		57,940		57,940		57,940			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,750	54,750		54,750		54,750			42
43	Other (specify):* Non-allowable Cost		392	53,350	53,742		53,742	(53,742)				43
44	TOTAL Special Cost Centers		58,332	108,100	166,432		166,432	(53,742)	112,690			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,263,293	326,404	999,675	2,589,372		2,589,372	111,700	2,701,072			45

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

Arcola Health Care Center

ID# 0046045

Report Period Beginning: 1/1/2009

Ending: 12/31/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (727)	43	1
2	X-Rays-Part A	(1,476)	43	2
3	Offset Vending Revenue	(16,900)	43	3
4	Offset Miscellaneous Office Supplies Revenue	(20)	10	4
5	Offset Miscellaneous Nursing Supplies Revenue	(86)	21	5
6	Resident Flowers	(667)	43	6
7	Disallowed Special Events	(1,650)	43	7
8	Offset Miscellaneous Nursing Supplies Revenue	(194)	11	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(21,720)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Arcola Health Care Center# 0046045

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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	5,049	0	0	0	0	0	0	0	0	0	5,049	1
2	Food Purchase	(4,428)	113	0	0	0	0	0	0	0	0	0	(4,315)	2
3	Housekeeping	0	48	0	0	0	0	0	0	0	0	0	48	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	498	0	0	0	0	0	0	0	0	0	498	5
6	Maintenance	0	2,445	0	0	0	0	0	0	0	0	0	2,445	6
7	Other (specify):*	0	912	0	0	0	0	0	0	0	0	0	912	7
8	TOTAL General Services	(4,428)	9,065	0	0	0	0	0	0	0	0	0	4,637	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(20)	3,056	0	0	0	0	0	0	0	0	0	3,036	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(194)	0	0	0	0	0	0	0	0	0	0	(194)	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	376	0	0	0	0	0	0	0	0	0	376	15
16	TOTAL Health Care and Programs	(214)	3,432	0	0	0	0	0	0	0	0	0	3,218	16
	C. General Administration													
17	Administrative	0	53,426	0	0	0	0	0	0	0	0	0	53,426	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	7,079	0	0	0	0	0	0	0	0	0	7,079	19
20	Fees, Subscriptions & Promotions	0	0	1,973	0	0	0	0	0	0	0	0	1,973	20
21	Clerical & General Office Expenses	(86)	0	51,481	0	0	0	0	0	0	0	0	51,395	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	525	0	0	0	0	0	0	0	0	525	23
24	Travel and Seminar	0	0	162	0	0	0	0	0	0	0	0	162	24
25	Other Admin. Staff Transportation	0	0	2,537	0	0	0	0	0	0	0	0	2,537	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,052	0	0	0	0	0	0	0	0	1,052	26
27	Other (specify):*	0	0	13,819	0	0	0	0	0	0	0	0	13,819	27
28	TOTAL General Administration	(86)	60,505	71,549	0	131,968	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(4,728)	73,002	71,549	0	139,823	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Arcola Health Care Center# 0046045

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)	
	D. Ownership													
30	Depreciation	13,827	0	4,161	0	0	0	0	0	0	0	0	17,988	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(20)	0	6,400	0	0	0	0	0	0	0	0	6,380	32
33	Real Estate Taxes	0	0	639	0	0	0	0	0	0	0	0	639	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	612	0	0	0	0	0	0	0	0	612	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	13,807	0	11,812	0	25,619	37							
	Ancillary Expense													
	E. Special Cost Centers													
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):*	(53,742)	0	0	0	0	0	0	0	0	0	0	(53,742)	43
44	TOTAL Special Cost Centers	(53,742)	0	0	0	0	0	0	0	0	0	0	(53,742)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(44,663)	73,002	83,361	0	0	0	0	0	0	0	0	111,700	45

Facility Name & ID Number

Arcola Health Care Center

0046045

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. 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)		
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 5,049	\$ 5,049	1	
2	V	2 Food		Petersen Health Care, Inc.	100.00%	113	113	2	
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	48	48	3	
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	0		4	
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	498	498	5	
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	2,445	2,445	6	
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	912	912	7	
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	3,056	3,056	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%	376	376	10	
11	V	17 Administrative		Petersen Health Care, Inc.	100.00%	53,426	53,426	11	
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	7,079	7,079	12	
13	V							13	
14	Total		\$			\$ 73,002	\$ *	73,002	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 <u>Dues, Fees, Subs and Promotions</u>	\$	<u>Petersen Health Care, Inc.</u>	100.00%	\$ 1,973	\$	1,973	15
16	V	21 <u>Clerical and General Office</u>		<u>Petersen Health Care, Inc.</u>	100.00%	51,481		51,481	16
17	V	23 <u>Inservice Training and Education</u>		<u>Petersen Health Care, Inc.</u>	100.00%	525		525	17
18	V	24 <u>Travel and Seminar</u>		<u>Petersen Health Care, Inc.</u>	100.00%	162		162	18
19	V	25 <u>Other Admin. Staff Transportation</u>		<u>Petersen Health Care, Inc.</u>	100.00%	2,537		2,537	19
20	V	26 <u>Insurance-Prop./Liab/Malpractice</u>		<u>Petersen Health Care, Inc.</u>	100.00%	1,052		1,052	20
21	V	27 <u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Care, Inc.</u>	100.00%	13,819		13,819	21
22	V	30 <u>Depreciation</u>		<u>Petersen Health Care, Inc.</u>	100.00%	4,161		4,161	22
23	V	32 <u>Interest</u>		<u>Petersen Health Care, Inc.</u>	100.00%	6,400		6,400	23
24	V	33 <u>Real Estate Taxes</u>		<u>Petersen Health Care, Inc.</u>	100.00%	639		639	24
25	V	34 <u>Rent-Facility and Grounds</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			25
26	V	35 <u>Rent-Equipment and Vehicles</u>		<u>Petersen Health Care, Inc.</u>	100.00%	612		612	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		\$			\$ 83,361	\$ *	83,361	39

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

Facility Name & ID Number

Arcola Health Care Center

0046045

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	155,831	1.13	1.88	Salary	\$ 3,282	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	\$ 3,282		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 Arcola Health Care Center

0046045

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

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

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

1	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	28,870	\$ 5,049	1
2	2	Food	Resident Days	1,493,044	75	5,864	0	28,870	113	2
3	3	Housekeeping	Resident Days	1,493,044	75	2,458	0	28,870	48	3
4	4	Laundry	Resident Days	1,493,044	75	0	0	28,870	0	4
5	5	Utilities	Resident Days	1,493,044	75	25,776	0	28,870	498	5
6	6	Maintenance	Resident Days	1,493,044	75	126,463	107,810	28,870	2,445	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	47,148	0	28,870	912	7
8	10	Nursing and Medical Records	Resident Days	1,493,044	75	158,020	151,697	28,870	3,056	8
9	10A	Therapy	Resident Days	1,493,044	75	0	0	28,870	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	19,462	0	28,870	376	10
11	17	Administrative	Resident Days	1,493,044	75	3,315,953	3,315,953	28,870	53,426	11
12	19	Professional Services	Resident Days	1,493,044	75	366,089	0	28,870	7,079	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,493,044	75	102,022	0	28,870	1,973	13
14	21	Clerical and General Office	Resident Days	1,493,044	75	2,662,394	2,253,243	28,870	51,481	14
15	23	Inservice Training & Education	Resident Days	1,493,044	75	27,176	0	28,870	525	15
16	24	Travel and Seminar	Resident Days	1,493,044	75	8,381	0	28,870	162	16
17	25	Other Admin. Staff Transport.	Resident Days	1,493,044	75	131,200	0	28,870	2,537	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,493,044	75	54,425	0	28,870	1,052	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	714,650	0	28,870	13,819	19
20	30	Depreciation	Resident Days	1,493,044	75	215,197	0	28,870	4,161	20
21	32	Interest	Resident Days	1,493,044	75	330,981	0	28,870	6,400	21
22	33	Real Estate Taxes	Resident Days	1,493,044	75	33,065	0	28,870	639	22
23	34	Rent-Facility and Grounds	Resident Days	1,493,044	75	0	0	28,870	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,493,044	75	31,635	0	28,870	612	24
25	TOTALS					\$ 8,639,461	\$ 6,088,287		\$ 156,363	25

Facility Name & ID Number

Arcola Health Care Center

0046045

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1	Bank of America	X	Mortgage	\$3,244 + int.	1/17/07	\$ 2,775,000	\$ 2,665,722	12/31/13	0.0832	\$ 150,050	1								
2	Ford Credit	X	Van Purchase	\$639.08	11/22/04	33,217		Paid	0.0590	164	2								
3						Interest Income Offset				(20)	3								
4						Home Office Allocation-PHC				6,400	4								
5											5								
Working Capital																			
6											6								
7											7								
8											8								
9	TOTAL Facility Related			\$639.08		\$ 2,808,217	\$ 2,665,722			\$ 156,594	9								
B. Non-Facility Related*																			
10											10								
11											11								
12											12								
13											13								
14	TOTAL Non-Facility Related					\$	\$			\$	14								
15	TOTALS (line 9+line14)					\$ 2,808,217	\$ 2,665,722			\$ 156,594	15								

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

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Arcola Health Care Center

0046045 Report Period Beginning:

1/1/2009 Ending:

12/31/2009

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 22,000 B. General Construction Type: Exterior Brick Frame Wood 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

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>159,865</u>	<u>1993</u>	<u>\$ 44,078</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	159,865		\$ 44,078	3

Facility Name & ID Number Arcola Health Care Center

0046045

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	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	100		1995	1975	\$ 859,153	\$	35	\$ 24,547	\$ 24,547	\$ 355,931	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvement		1993		13,499		20	675	675	11,137	9
10	Building Improvement		1994		31,000		20	1,550	1,550	23,975	10
11	Building Improvement		1995		10,602		20	530	530	7,930	11
12	Landscaping		1997		5,593		20	280	280	3,499	12
13	Parking Lot		1997		6,500		20	325	325	4,063	13
14	Carpeting		1997		934		20	47	47	586	14
15	Door Closer		1997		1,225		20	61	61	764	15
16	Driveway Grading		1998		784		15	52	52	599	16
17	Guttering		1998		1,273		15	85	85	977	17
18	Wiring		1998		6,426		20	321	321	3,693	18
19	Windows		1998		2,330		15	155	155	1,784	19
20	Siding		1998		12,606		20	630	630	7,246	20
21	Doors		1998		765		15	51	51	587	21
22	Sink		1998		901		20	45	45	720	22
23	Garage		1998		8,286		15	552	552	6,349	23
24	Wood Flooring		1999		1,174		20	59	59	618	24
25	Asphalt Lot		1999		4,680		20	234	234	2,457	25
26	Tile		1999		6,477		20	324	324	3,400	26
27	Vinyl Siding		1999		5,600		25	224	224	2,352	27
28	Door Alarms		2000		1,593		20	80	80	759	28
29	Water Heater		2000		5,075		20	254	254	2,413	29
30	Sidewalk		2000		876		20	44	44	418	30
31	Carpeting		2000		670		20	34	34	322	31
32	Scarf Swags/Valances		2001		6,043		20	302	302	2,416	32
33	Scarf Holders		2001		1,083		20	54	54	432	33
34	Fence		2001		2,000		20	100	100	800	34
35	Replacement Wall		2001		686		20	34	34	273	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 Arcola Health Care Center

0046045

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	2	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	Security System	2002	\$ 5,959	\$	20	\$ 298	\$ 298	\$ 2,235	37
38	Sprinkler System	2002	4,946		20	247	247	1,855	38
39	Sign	2002	1,248		20	62	62	854	39
40	Medicare Wing Expansion	2003	100,808		20	5,040	5,040	32,761	40
41	Architect Fees	2003	1,343		20	67	67	469	41
42	Patio	2003	5,858		20	293	293	2,051	42
43	Medicare Wing Expansion	2003	2,500		20	125	125	813	43
44	Medicare Wing Expansion	2003	750		20	38	38	245	44
45	Medicare Wing Expansion	2003	1,500		20	75	75	488	45
46	Medicare Wing Expansion	2003	500		20	25	25	163	46
47	Furnace	2004	2,195		20	110	110	605	47
48	Roofing	2005	2,500		20	125	125	564	48
49	Asphalt West Lot	2006	21,480		20	1,074	1,074	3,759	49
50	Door Alarm	2007	2,117		10	212	212	530	50
51	Furnace/Air Conditioner	2007	3,985		10	399	399	997	51
52	Blinds	2007	4,431		10	443	443	1,108	52
53	Windows	2007	19,021		20	951	951	2,378	53
54	Water Heater	2008	6,500		7	928	928	1,392	54
55	Boiler	2008	3,425		20	172	172	258	55
56	6 New Sprinklers	2008	5,990		25	240	240	360	56
57	Fire Alarm Repair	2008	2,899		7	414	414	621	57
58									58
59									59
60	Land Improvement Depreciation			1,871			(1,871)		60
61	Building Booked			23,372			(23,372)		61
62	Building Improvement Booked			9,488			(9,488)		62
63									63
64									64
65	2009-Home Office Allocation-Land Improvements		950			60	60		65
66	2009-Home Office Allocation-Building Improvements		14,913			340	340		66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,213,652	\$ 34,731		\$ 43,387	\$ 8,656	\$ 501,006	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	\$ 129,133	\$ 7,376	\$ 12,913	\$ 5,537	10 yrs.	\$ 93,180	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	128,973					128,973	73
74	Home Office Allocation			4,161	4,161			74
75	TOTALS	\$ 258,106	\$ 7,376	\$ 17,074	\$ 9,698		\$ 222,153	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	Facility	1994 Dodge Van	1998	\$ 28,010	\$ 1,775	\$	(1,775)	5	\$ 28,010	76
77	Facility	2005 Ford	2004	33,217	1,913	3,322	1,409	5	33,217	77
78										78
79										79
80	TOTALS			\$ 61,227	\$ 3,688	\$ 3,322	\$ (366)		\$ 61,227	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,577,063	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 45,795	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 63,783	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 17,988	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 784,386	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	TOTAL				\$ _____			7

8. List separately any amortization of lease expense included on page 4, line 34. _____

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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: \$ 8,778 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	TOTAL		\$ _____	\$ _____	21

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 \$ _____

* 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.

Arcola Health Care Center

0038919

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	\$	4,221
Laundry	\$	237
Dishwasher		708
Copier		3,000
Home Office Allocation		612
		<u>8,778</u>

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>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</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>2. CLASSROOM PORTION:</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>3. CLINICAL PORTION:</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	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	3,598	\$ 53,963	\$	3,598	\$ 53,963	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,345	20,179		1,345	20,179	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		3,400	51,006	277	3,400	51,283	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 prescripts				57,940		57,940	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			\$	8,343	\$ 125,148	\$ 58,217	8,343	\$ 183,365	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 Arcola Health Care Center# 0046045Report 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*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,517,979	\$ 1,517,979	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>N/A</u>)	314,200	314,200	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	49,849	49,849	6
7	Other Prepaid Expenses	12,222	12,222	7
8	Accounts Receivable (owners or related parties)	2,608,147	2,608,147	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,502,397	\$ 4,502,397	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		44,078	13
14	Buildings, at Historical Cost	941,489	874,066	14
15	Leasehold Improvements, at Historical Cost	248,056	339,586	15
16	Equipment, at Historical Cost	338,206	319,333	16
17	Accumulated Depreciation (book methods)	(724,303)	(784,386)	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)	\$ 803,448	\$ 792,677	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,305,845	\$ 5,295,074	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 392,939	\$ 392,939	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	80,692	80,692	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,138	2,138	31
32	Accrued Real Estate Taxes(Sch.IX-B)	26,600	26,600	32
33	Accrued Interest Payable	13,627	13,627	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	70,567	70,567	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 586,563	\$ 586,563	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,665,722	2,665,722	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,665,722	\$ 2,665,722	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,252,285	\$ 3,252,285	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,053,560	\$ 2,042,789	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,305,845	\$ 5,295,074	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,611,688	1
2	Restatements (describe):		2
3	<u>Rounding</u>	<u>2</u>	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,611,690	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	441,870	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 441,870	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,053,560	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Arcola Health Care Center# 0046045Report 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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,789,434	1
2	Discounts and Allowances for all Levels	(49,929)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,739,505	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	209,644	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 209,644	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	4,428	14
15	Telephone, Television and Radio	6,255	15
16	Rental of Facility Space		16
17	Sale of Drugs	47,746	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	3,404	20
21	Other Medical Services	2,958	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 64,791	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	20	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 20	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Revenue</u>	300	28
28a	<u>Vending Income</u>	16,982	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 17,282	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,031,242	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	640,045	31
32	Health Care	1,273,276	32
33	General Administration	278,991	33
B. Capital Expense			
34	Ownership	230,628	34
C. Ancillary Expense			
35	Special Cost Centers	111,682	35
36	Provider Participation Fee	54,750	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,589,372	40
41	Income before Income Taxes (line 30 minus line 40)**	441,870	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 441,870	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 Arcola Health Care Center

0046045

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	937	937	24,335	\$ 25.97	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,410	3,845	88,997	23.15	3
4	Licensed Practical Nurses	11,059	11,422	212,255	18.58	4
5	CNAs & Orderlies	37,367	38,855	385,999	9.93	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	723	731	6,970	9.53	9
10	Activity Assistants	2,623	2,729	24,397	8.94	10
11	Social Service Workers	4,737	4,745	63,145	13.31	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	29,762	14.31	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,579	14,121	114,892	8.14	15
16	Dishwashers					16
17	Maintenance Workers	2,116	2,292	27,949	12.19	17
18	Housekeepers	11,687	12,178	97,994	8.05	18
19	Laundry	6,674	7,099	56,978	8.03	19
20	Administrator	2,080	2,080	66,394	31.92	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	835	890	9,273	10.42	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: Transportation	1,836	2,014	21,771	10.81	32
33	Other(specify) <u>Care Plan Coord.</u>	3,919	3,971	82,326	20.73	33
34	TOTAL (lines 1 - 33)	105,662	109,989	\$ 1,313,437 *	\$ 11.94	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	\$		35	
36	Medical Director	Monthly	34,800	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,200	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)	\$	36,000		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	7	\$ 308	10(3)	50
51	Licensed Practical Nurses	2,113	75,515	10(3)	51
52	Certified Nurse Assistants/Aides	2,773	56,029	10(3)	52
53	TOTAL (lines 50 - 52)	4,893	\$ 131,852		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	
Karla Schneider	Adminrator	0	\$ 66,394	Workers' Compensation Insurance	\$ 47,487	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance	19,769	Advertising: Employee Recruitment	1,053	
				FICA Taxes	94,459	Health Care Worker Background Check		
				Employee Health Insurance	26,148	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks	108 1,080	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	487	
				Employee Relations	328	Miscellaneous Dues & Subscriptions	60	
				Employee Retirement	777	IHCA Dues	1,500	
						Home Office Allocation	1,973	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 66,394			Less: Public Relations Expense	()	
(List each licensed administrator separately.)						Non-allowable advertising	()	
						Yellow page advertising	()	
B. Administrative - Other						TOTAL (agree to Sch. V, line 20, col. 8)		
Description			Amount				\$ 8,143	
N/A			\$					
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL (agree to Schedule V, line 22, col.8)			\$ 188,968	
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
E-Health Data Solutions	Computer Services		\$ 2,700				Out-of-State Travel	\$
Consolidated Communications	Computer Services		797					
LTC Solutions	Computer Services		1,700				In-State Travel	
				N/A				
							Seminar Expense	
							Home Office Allocation	162
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)			\$ 5,197	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)							TOTAL	\$ 162

* Attach copy of IMRF notifications

**See instructions.

Arcola Health Care Center

0046045

Period Beginning 1/1/2009

Period End 12/31/2009

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		5,197

Home Office Allocation

Heyl, Royster, Voelker & Allen	Legal	45
GoffWilson, P.A.	Legal	64
Jackson Lewis	Legal	507
Peter Gartelos	Legal	49
Misc.	Legal	44
Ginoli & Company	Accountants	1,126
Miscellaneous Vendors	Computer Services	47
Emdeon Business Services	Computer Services	21
Advanced Answers on Demand	Computer Services	2,720
Access 2 Go	Computer Services	261
Ivans	Computer Services	31
Kemper Technology	Computer Services	739
VisionShare	Computer Services	230
MediFax	Computer Services	94
LogmeIn	Computer Services	41
Charter Communications	Computer Services	2
Simple LTC	Computer Services	627
Miscellaneous Vendors	Miscellaneous	431
Total (agree to Schedule V, line 19, column 8)		<u>12,276</u>

Facility Name & ID Number Arcola Health Care Center# 0046045Report 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. 1,500 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. \$ 5,650 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. \$ 54,750
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. \$ 4,428
- (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.