



Facility Name & ID Number Batavia Rehabilitation & Health Care Center

# 0047399 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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	63	Intermediate (ICF)	63	22,995	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	63	TOTALS	63	22,995	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					8
9	SNF/PED					9
10	ICF	13,668	1,475	559	15,702	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,668	1,475	559	15,702	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.28%

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 10/1/2005

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 10/1/2005 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 0 and days of care provided 0

Medicare Intermediary N/A

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 Batavia Rehabilitation & Health Care Center # 0047399 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
	<b>A. General Services</b>										
1	Dietary	134,853	9,610	5,280	149,743		149,743	2,746	152,489		1
2	Food Purchase		84,398		84,398		84,398	(866)	83,532		2
3	Housekeeping	85,257	14,055		99,312		99,312	26	99,338		3
4	Laundry	22,755	3,728		26,483		26,483		26,483		4
5	Heat and Other Utilities			49,987	49,987		49,987	271	50,258		5
6	Maintenance	33,875	14,489	30,554	78,918		78,918	2,870	81,788		6
7	Other (specify):* Home Off. Ben. All.							496	496		7
8	<b>TOTAL General Services</b>	276,740	126,280	85,821	488,841		488,841	5,543	494,384		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			7,200	7,200		7,200		7,200		9
10	Nursing and Medical Records	786,954	53,251	26,766	866,971		866,971	1,587	868,558		10
10a	Therapy		13		13		13		13		10a
11	Activities	22,964	356	145	23,465		23,465		23,465		11
12	Social Services	25,568			25,568		25,568		25,568		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.							205	205		15
16	<b>TOTAL Health Care and Programs</b>	835,486	53,620	34,111	923,217		923,217	1,792	925,009		16
	<b>C. General Administration</b>										
17	Administrative	18,313		108,000	126,313		126,313	(52,692)	73,621		17
18	Directors Fees										18
19	Professional Services			25,124	25,124		25,124	4,923	30,047		19
20	Dues, Fees, Subscriptions & Promotions			5,470	5,470		5,470	1,780	7,250		20
21	Clerical & General Office Expenses	28,989	3,719	6,373	39,081		39,081	30,272	69,353		21
22	Employee Benefits & Payroll Taxes			140,825	140,825		140,825		140,825		22
23	Inservice Training & Education			155	155		155	286	441		23
24	Travel and Seminar							88	88		24
25	Other Admin. Staff Transportation			2,490	2,490		2,490	1,656	4,146		25
26	Insurance-Prop.Liab.Malpractice			67,932	67,932		67,932	572	68,504		26
27	Other (specify):* Home Off. Ben. All.							10,826	10,826		27
28	<b>TOTAL General Administration</b>	47,302	3,719	356,369	407,390		407,390	(2,289)	405,101		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,159,528	183,619	476,301	1,819,448		1,819,448	5,046	1,824,494		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.

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			14,220	14,220		14,220	6,755	20,975			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			14,937	14,937		14,937	20,849	35,786			32
33	Real Estate Taxes			45,738	45,738		45,738	348	46,086			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			10,899	10,899		10,899	333	11,232			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			85,794	85,794		85,794	28,285	114,079			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			34,493	34,493		34,493		34,493			42
43	Other (specify):*		437	15,142	15,579		15,579	(15,579)				43
44	<b>TOTAL Special Cost Centers</b>		437	49,635	50,072		50,072	(15,579)	34,493			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,159,528	184,056	611,730	1,955,314		1,955,314	17,752	1,973,066			45

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



Batavia Rehabilitation & Health Care Center

ID# 0047399

Report Period Beginning: 1/1/2009

Ending: 12/31/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Offset Miscellaneous Office Supplies Revenue	(140)	21	1
2	Offset Chamber of Commerce Dues	(410)	20	2
3	Disallowed Special Events	(638)	43	3
4	Offset Miscellaneous Nursing Supplies	(75)	10	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(1,263)		49

**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%	\$ 2,746	\$ 2,746	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	62	62	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	26	26	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	271	271	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	1,330	1,330	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	496	496	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	1,662	1,662	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%	205	205	10
11	V	17 Administrative	108,000	Petersen Health Care, Inc.	100.00%	55,308	(52,692)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	3,850	3,850	12
13	V							13
14	Total		\$ 108,000			\$ 65,956	\$ * (42,044)	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	20 Dues, Fees, Subs and Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 1,073	\$	1,073	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	28,000		28,000	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	286		286	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	88		88	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	1,380		1,380	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	572		572	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	7,516		7,516	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	2,263		2,263	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	3,481		3,481	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	348		348	24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0			25
26	V	35 Rent-Equipment and Vehicles		Petersen Health Care, Inc.	100.00%	333		333	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		\$			\$ 45,340	\$ *	45,340	39

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

Facility Name & ID Number Batavia Rehabilitation & Health Care Center# 0047399Report Period Beginning: 1/1/2009Ending: 12/31/2009

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1 Dietary	\$	Petersen Health Operations, LLC	100.00%	\$ 0	\$	15	
16	V	2 Food		Petersen Health Operations, LLC	100.00%	0		16	
17	V	3 Housekeeping		Petersen Health Operations, LLC	100.00%	0		17	
18	V	4 Laundry		Petersen Health Operations, LLC	100.00%	0		18	
19	V	5 Utilities		Petersen Health Operations, LLC	100.00%	0		19	
20	V	6 Maintenance		Petersen Health Operations, LLC	100.00%	1,540	1,540	20	
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	0		21	
22	V	10 Nursing and Medical Records		Petersen Health Operations, LLC	100.00%	0		22	
23	V	10A Therapy		Petersen Health Operations, LLC	100.00%	0		23	
24	V	15 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	0		24	
25	V	17 Administrative		Petersen Health Operations, LLC	100.00%	0		25	
26	V	19 Professional Services		Petersen Health Operations, LLC	100.00%	1,073	1,073	26	
27	V	20 Dues, Fees, Subs & Promotions		Petersen Health Operations, LLC	100.00%	1,117	1,117	27	
28	V	21 Clerical and General Office		Petersen Health Operations, LLC	100.00%	2,412	2,412	28	
29	V	23 Inservice Training & Education		Petersen Health Operations, LLC	100.00%	0		29	
30	V	24 Travel and Seminar		Petersen Health Operations, LLC	100.00%	0		30	
31	V	25 Other Admin. Staff Transport.		Petersen Health Operations, LLC	100.00%	276	276	31	
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Operations, LLC	100.00%	0		32	
33	V	27 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	3,310	3,310	33	
34	V	30 Depreciation		Petersen Health Operations, LLC	100.00%	958	958	34	
35	V	32 Interest		Petersen Health Operations, LLC	100.00%	17,418	17,418	35	
36	V	33 Real Estate Taxes		Petersen Health Operations, LLC	100.00%	0		36	
37	V	34 Rent-Facility and Grounds		Petersen Health Operations, LLC	100.00%	0		37	
38	V	35 Rent-Equipment & Vehicles		Petersen Health Operations, LLC	100.00%	0		38	
39	Total		\$			\$ 28,104	\$ *	28,104	39

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

Facility Name & ID Number Batavia Rehabilitation & Health Care Cente # 0047399 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Petersen	President	Administrative	100.00	157,328	0.61	1.02	Salary	\$ 1,785	L17, C7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 1,785		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 Batavia Rehabilitation & Health Care Center # 0047399 Report Period Beginning: 1/1/2009 Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,493,044	75	\$ 261,102	\$ 259,584	15,702	\$ 2,746	1
2	2	Food	Resident Days	1,493,044	75	5,864	0	15,702	62	2
3	3	Housekeeping	Resident Days	1,493,044	75	2,458	0	15,702	26	3
4	4	Laundry	Resident Days	1,493,044	75	0	0	15,702	0	4
5	5	Utilities	Resident Days	1,493,044	75	25,776	0	15,702	271	5
6	6	Maintenance	Resident Days	1,493,044	75	126,463	107,810	15,702	1,330	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	47,148	0	15,702	496	7
8	10	Nursing and Medical Records	Resident Days	1,493,044	75	158,020	151,697	15,702	1,662	8
9	10A	Therapy	Resident Days	1,493,044	75	0	0	15,702	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	19,462	0	15,702	205	10
11	17	Administrative	Resident Days	1,493,044	75	3,315,953	3,315,953	15,702	55,308	11
12	19	Professional Services	Resident Days	1,493,044	75	366,089	0	15,702	3,850	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,493,044	75	102,022	0	15,702	1,073	13
14	21	Clerical and General Office	Resident Days	1,493,044	75	2,662,394	2,253,243	15,702	28,000	14
15	23	Inservice Training & Education	Resident Days	1,493,044	75	27,176	0	15,702	286	15
16	24	Travel and Seminar	Resident Days	1,493,044	75	8,381	0	15,702	88	16
17	25	Other Admin. Staff Transport.	Resident Days	1,493,044	75	131,200	0	15,702	1,380	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,493,044	75	54,425	0	15,702	572	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	714,650	0	15,702	7,516	19
20	30	Depreciation	Resident Days	1,493,044	75	215,197	0	15,702	2,263	20
21	32	Interest	Resident Days	1,493,044	75	330,981	0	15,702	3,481	21
22	33	Real Estate Taxes	Resident Days	1,493,044	75	33,065	0	15,702	348	22
23	34	Rent-Facility and Grounds	Resident Days	1,493,044	75	0	0	15,702	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,493,044	75	31,635	0	15,702	333	24
25	TOTALS					\$ 8,639,461	\$ 6,088,287		\$ 111,296	25

Facility Name & ID Number Batavia Rehabilitation & Health Care Center

# 0047399

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

1	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	398,596	21	\$	(1)	15,702	\$	1
2	2	Food	Resident Days	398,596	21			15,702		2
3	3	Housekeeping	Resident Days	398,596	21			15,702		3
4	4	Laundry	Resident Days	398,596	21			15,702		4
5	5	Utilities	Resident Days	398,596	21			15,702		5
6	6	Maintenance	Resident Days	398,596	21	39,101		15,702	1,540	6
7	7	Mgmt. Allocation of Benefits	Resident Days	398,596	21			15,702		7
8	10	Nursing and Medical Records	Resident Days	398,596	21			15,702		8
9	10A	Therapy	Resident Days	398,596	21			15,702		9
10	15	Mgmt. Allocation of Benefits	Resident Days	398,596	21			15,702		10
11	17	Administrative	Resident Days	398,596	21		(2)	15,702		11
12	19	Professional Services	Resident Days	398,596	21	27,246		15,702	1,073	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	398,596	21	28,361		15,702	1,117	13
14	21	Clerical and General Office	Resident Days	398,596	21	61,225		15,702	2,412	14
15	23	Inservice Training & Education	Resident Days	398,596	21			15,702		15
16	24	Travel and Seminar	Resident Days	398,596	21			15,702		16
17	25	Other Admin. Staff Transport.	Resident Days	398,596	21	7,017		15,702	276	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	398,596	21			15,702		18
19	27	Mgmt. Allocation of Benefits	Resident Days	398,596	21	84,022		15,702	3,310	19
20	30	Depreciation	Resident Days	398,596	21	24,325		15,702	958	20
21	32	Interest	Resident Days	398,596	21	442,158		15,702	17,418	21
22	33	Real Estate Taxes	Resident Days	398,596	21			15,702		22
23	34	Rent-Facility and Grounds	Resident Days	398,596	21			15,702		23
24	35	Rent-Equipment & Vehicles	Resident Days	398,596	21			15,702		24
25	TOTALS					\$ 713,455	\$		\$ 28,104	25

Facility Name & ID Number

Batavia Rehabilitation & Health Care Center

# 0047399

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			
<b>A. Directly Facility Related</b>																			
<b>Long-Term</b>																			
1	Bank of America		X	Mortgage	Varies	1/19/07	\$ 300,000	\$ 291,179	12/31/13	Varies	\$ 14,937	1							
2												2							
3							Interest Income Offset				(50)	3							
4							Home Office Allocation-PHC				3,481	4							
5							Home Office Allocation-PHO				17,418	5							
<b>Working Capital</b>																			
6												6							
7												7							
8												8							
9	<b>TOTAL Facility Related</b>						\$ 300,000	\$ 291,179			\$ 35,786	9							
<b>B. Non-Facility Related*</b>																			
10												10							
11												11							
12												12							
13												13							
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14							
15	<b>TOTALS (line 9+line14)</b>						\$ 300,000	\$ 291,179			\$ 35,786	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.)





**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 14,290 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

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F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
 If so, please complete the following:

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
 3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs: \_\_\_\_\_  
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

**XI. OWNERSHIP COSTS:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>79,279</u>	<u>2005</u>	<u>\$ 110,500</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>79,279</b>		<b>\$ 110,500</b>	<b>3</b>

**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	63		2005	1972	\$ ***	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		Tile	2005		8,119		20	406	406	1,827	9
10		Sidewalks	2006		14,105		15	940	940	3,290	10
11		Roof	2006		18,900		10	1,890	1,890	6,615	11
12		Water Heater	2007		950		10	95	95	238	12
13		Backflow	2007		6,490		10	649	649	1,623	13
14		Laundry Room Drywall and Replacement of Sub-Floor	2007		7,430		20	372	372	930	14
15		Sprinkler System	2007		3,792		15	252	252	630	15
16		Shower Room Repairs	2008		4,600		39	118	118	177	16
17		Roof Repair	2008		3,480		25	140	140	210	17
18		Furnace	2008		4,200		5	840	840	1,260	18
19		Water Heater-100 Gallon	2008		12,377		7	1,768	1,768	2,652	19
20		Carpeting	2008		34,139		15	2,276	2,276	3,414	20
21		Floor Tiling-Store Room & Lunch Room	2009		7,435		15	248	248	248	21
22		Sprinkler System Repair	2009		16,775		15	559	559	559	22
23		Floor Tiling-Kitchen	2009		20,746		15	692	692	692	23
24											24
25											25
26											26
27											27
28		*** Note:									28
29		Facility was purchased as part of a multi-facility									29
30		sale. For purposes of allocating the purchase									30
31		price, appraisers valued the building and land									31
32		at the value of the bare land, only. The allocated									32
33		amount appears on page 11 (Sch. XI (A) line 1, column 4.									33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55	Land Improvements Booked		940			(940)		55
56	Building Improvement Booked		7,114			(7,114)		56
57								57
58								58
59	2009-Home Office Allocation-Land Improvements	516			32	32		59
60	2009-Home Office Allocation-Building Improvements	7,719			185	185		60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 171,773	\$ 8,054		\$ 11,462	\$ 3,408	\$ 24,365	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	\$ 43,426	\$ 5,840	\$ 5,835	\$ (5)	7-10 yrs.	\$ 23,836	71
72	Current Year Purchases	9,133	326	457	131	10 yrs.	457	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			3,221	3,221			74
75	TOTALS	\$ 52,559	\$ 6,166	\$ 9,513	\$ 3,347		\$ 24,293	75

D. Vehicle Depreciation (See instructions.)\*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 334,832	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 14,220	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 20,975	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 6,755	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 48,658	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: \$ 4,369 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	Facility	2006 Ford E250	\$ 572	\$ 6,863	17
18					18
19					19
20					20
21	TOTAL		\$ 572.00	\$ 6,863	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.

**Batavia Rehabilitation & Health Care Center**  
**0047399**  
**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	\$	859
Dishwasher		708
Copier		2,469
Home Office Allocation		333
		<u>4,369</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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><b>2. CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

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

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

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

	Service	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
					Units	Cost					
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1	
2	Licensed Speech and Language Development Therapist		hrs							2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	10A(2)	hrs				13		13	4	
5	Physician Care		visits							5	
6	Dental Care		visits							6	
7	Work Related Program		hrs							7	
8	Habilitation		hrs							8	
9	Pharmacy		# of prescripts							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			\$		\$	\$ 13		\$ 13	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 **Batavia Rehabilitation & Health Care Center**

# **0047399**

Report Period Beginning: **1/1/2009**

Ending: **12/31/2009**

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

As of **12/31/2009** (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 148,067	\$ 148,067	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>5,000</u> )	210,597	210,597	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	31,405	31,405	6
7	Other Prepaid Expenses	8,400	8,400	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	35,000	35,000	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 433,469	\$ 433,469	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	124,605	110,500	13
14	Buildings, at Historical Cost		7,719	14
15	Leasehold Improvements, at Historical Cost	130,533	164,054	15
16	Equipment, at Historical Cost	52,559	52,559	16
17	Accumulated Depreciation (book methods)	(37,984)	(48,658)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 269,713	\$ 286,174	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 703,182	\$ 719,643	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 278,707	\$ 278,707	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	24,397	24,397	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,019	2,019	31
32	Accrued Real Estate Taxes(Sch.IX-B)	45,000	45,000	32
33	Accrued Interest Payable	1,302	1,302	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Payroll Withholdings</u>	46,999	46,999	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 398,424	\$ 398,424	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable	291,179	291,179	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 291,179	\$ 291,179	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 689,603	\$ 689,603	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 13,579	\$ 30,040	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 703,182	\$ 719,643	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>91,867</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>2008 Bad Debt Allowance Entered After CR Completion</b>	<b>(5,000)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>86,867</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(73,288)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(73,288)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>13,579</b>	<b>24</b> *

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

Facility Name & ID Number **Batavia Rehabilitation & Health Care Center**# **0047399**Report Period Beginning: **1/1/2009**Ending: **12/31/2009**

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

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 1,880,833	1
2	Discounts and Allowances for all Levels		2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 1,880,833	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	928	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 928	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	50	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 50	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Miscellaneous Revenue</u>	215	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 215	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 1,882,026	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	488,841	31
32	Health Care	923,217	32
33	General Administration	407,390	33
<b>B. Capital Expense</b>			
34	Ownership	85,794	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	15,579	35
36	Provider Participation Fee	34,493	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 1,955,314	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(73,288)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (73,288)	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 **Batavia Rehabilitation & Health Care Center**

# **0047399**

Report Period Beginning: **1/1/2009**

Ending:

**12/31/2009**

**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,088	2,088	\$ 63,724	\$ 30.52	1
2	Assistant Director of Nursing	1,872	1,872	54,143	28.92	2
3	Registered Nurses	5,950	6,066	175,449	28.92	3
4	Licensed Practical Nurses	7,418	7,576	202,137	26.68	4
5	CNAs & Orderlies	25,549	26,101	291,501	11.17	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,992	1,995	22,154	11.10	9
10	Activity Assistants	23	23	253	11.00	10
11	Social Service Workers	1855	1,855	25,568	13.78	11
12	Dietician					12
13	Food Service Supervisor	2,199	2,319	33,913	14.62	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,699	8,847	100,940	11.41	15
16	Dishwashers					16
17	Maintenance Workers	1,995	2,049	33,875	16.53	17
18	Housekeepers	7,874	8,225	85,257	10.37	18
19	Laundry	1,859	1,982	22,755	11.48	19
20	Administrator	2,131	2,131	71,836	33.71	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,862	1,958	28,989	14.81	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 Care(specify)					32
33	Other(specify) <u>Transportation</u>	42	42	557	13.26	33
34	TOTAL (lines 1 - 33)	73,408	75,129	\$ 1,213,051 *	\$ 16.15	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	Monthly	\$ 5,280	1(3) 35
36	Medical Director	Monthly	7,200	9(3) 36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly	600	10(3) 39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)		\$ 13,080	49

**C. CONTRACT NURSES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	546	\$ 25,621	10(3) 50
51	Licensed Practical Nurses	14	545	10(3) 51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)	560	\$ 26,166	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		
Teri Rebstock	Administrator	0	\$ 71,836	Workers' Compensation Insurance	\$ 31,572	IDPH License Fee	\$ 995		
				Unemployment Compensation Insurance	19,294	Advertising: Employee Recruitment	888		
				FICA Taxes	88,630	Health Care Worker Background Check			
				Employee Health Insurance	(893)	(Indicate # of checks performed)			
				Employee Meals		Patient Background Checks	105 1,052		
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	625		
				Employee Relations	1,326	Miscellaneous Dues & Subscriptions	410		
				Employee Retirement	896	IHCA Dues	1,500		
						Home Office Allocation	2,190		
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 71,836			Less: Public Relations Expense	(410)		
(List each licensed administrator separately.)						Non-allowable advertising	( )		
						Yellow page advertising	( )		
<b>B. Administrative - Other</b>									
Description			Amount	TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)		
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 108,000	\$ 140,825			\$ 7,250		
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 108,000	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
(Attach a copy of any management service agreement)				Description			Description		
<b>C. Professional Services</b>				Line #			Amount		
Vendor/Payee	Type	Amount	Description			Amount			
E-Health Data Solutions	Computer Services	\$ 2,700	N/A			Out-of-State Travel			
AT&T	Computer Services	480							
LTC Solutions	Computer Services	1,700							
SimpleLTC, Inc.	Computer Services	81				In-State Travel			
Cassiday Schade LLP	Legal Services	15,150							
Michael Todd Grendon, MD	Legal Services	2,713							
Nigro, Westfall & Gryska PC	Legal Services	700				Seminar Expense			
Janice Colwell	Legal Services	1,600				Home Office Allocation			
						88			
						Entertainment Expense			
						( )			
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			(agree to Sch. V, line 24, col. 8)		
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 25,124	\$			TOTAL \$ 88		

\* Attach copy of IMRF notifications

\*\*See instructions.

**Batavia Rehabilitation & Health Care Center**

**0047399**

**Period Beginning 1/1/2009**

**Period End 12/31/2009**

**Schedule 21A**

**XIX. SUPPORT SCHEDULE**

**C. Professional Services**

<b>Vendor/Payee</b>	<b>Type</b>	<b>Amount</b>
Total (agree to Schedule V, line 19, column 3)		25,124

**Home Office Allocation**

Heyl, Royster, Voelker & Allen	Legal	(11)
GoffWilson, P.A.	Legal	35
Jackson Lewis	Legal	276
Peter Gartelos	Legal	27
Misc.	Legal	24
Ginoli & Company	Accountants	1,661
Miscellaneous Vendors	Computer Services	26
Emdeon Business Services	Computer Services	12
Advanced Answers on Demand	Computer Services	1,479
Access 2 Go	Computer Services	142
Ivans	Computer Services	77
Kemper Technology	Computer Services	402
VisionShare	Computer Services	125
MediFax	Computer Services	51
LogmeIn	Computer Services	22
Charter Communications	Computer Services	1
Simple LTC	Computer Services	341
Miscellaneous Vendors	Miscellaneous	232
Total (agree to Schedule V, line 19, column 8)		<u>30,046</u>

**Batavia Rehabilitation & Health Care Center**

**0047399**

**Period Beginning 1/1/2009**

**Period End 12/31/2009**

**Schedule 21B**

**XIX. SUPPORT SCHEDULE**

**Legal Fees**

**Facility**

<b>Vendor/Payee</b>	<b>Invoice Total</b>	<b>Allocation %</b>	<b>Total</b>
Cassiday Schade, LLP	15,150.43	100%	15,150
Michael Todd Grendon, MD	2,712.50	100%	2,713
Nigro, Westfall, Gryska, P.C.	700.00	100%	700
Janice C. Colwell	1,600.00	100%	1,600

**Home Office Allocation**

Heyl, Royster, Voelker, and Allen	2,414.77	1.03%	25
GoffWilson	3,425.00	1.03%	35
Jackson Lewis	27,043.20	1.03%	276
Peter Gartelos	2,612.50	1.03%	27
Miscellaneous Vendors	2,327.62	1.03%	24

**Management Company Allocation**

Heyl, Royster, Voelker, and Allen	(927.00)	3.89%	(36)
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**Total Legal Fees**

20,513



Facility Name & ID Number Batavia Rehabilitation & Health Care Center# 0047399Report 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. \$ 11,870 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. \$ 34,493  
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. \$ 928
- (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? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.