

Facility Name & ID Number Cisne Rehabilitation & Health Care Center

0047423 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	11	Skilled (SNF)	11	4,015	1
2		Skilled Pediatric (SNF/PED)			2
3	24	Intermediate (ICF)	24	8,760	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	35	TOTALS	35	12,775	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 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF			1,319	1,319		8
9	SNF/PED						9
10	ICF	7,613	1,960	68	9,641		10
11	ICF/DD						11
12	SC						12
13	DD 16 OR LESS						13
14	TOTALS	7,613	1,960	1,387	10,960		14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.79%

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)

Meals on Wheels

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 11 and days of care provided 1,319

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 Cisne Rehabilitation & Health Care Center # 0047423 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	73,583	5,784		79,367		79,367	1,917	81,284		1
2	Food Purchase		61,826		61,826		61,826	(4,005)	57,821		2
3	Housekeeping	28,730	11,152		39,882		39,882	18	39,900		3
4	Laundry	15,887	5,282		21,169		21,169		21,169		4
5	Heat and Other Utilities			32,334	32,334		32,334	189	32,523		5
6	Maintenance	2,837	3,521	16,945	23,303		23,303	2,002	25,305		6
7	Other (specify):* Home Off. Ben. All.							346	346		7
8	TOTAL General Services	121,037	87,565	49,279	257,881		257,881	467	258,348		8
	B. Health Care and Programs										
9	Medical Director			8,400	8,400		8,400		8,400		9
10	Nursing and Medical Records	402,295	29,899	1,186	433,380		433,380	1,160	434,540		10
10a	Therapy	30,383	120		30,503		30,503		30,503		10a
11	Activities	28,247	160	24	28,431		28,431		28,431		11
12	Social Services	20,659			20,659		20,659		20,659		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.							143	143		15
16	TOTAL Health Care and Programs	481,584	30,179	9,610	521,373		521,373	1,303	522,676		16
	C. General Administration										
17	Administrative	9,750		62,000	71,750		71,750	(31,504)	40,246		17
18	Directors Fees										18
19	Professional Services			4,901	4,901		4,901	3,435	8,336		19
20	Dues, Fees, Subscriptions & Promotions			4,513	4,513		4,513	1,528	6,041		20
21	Clerical & General Office Expenses		3,326	7,381	10,707		10,707	21,064	31,771		21
22	Employee Benefits & Payroll Taxes			84,710	84,710		84,710		84,710		22
23	Inservice Training & Education			170	170		170	199	369		23
24	Travel and Seminar			170	170		170	62	232		24
25	Other Admin. Staff Transportation			3,673	3,673		3,673	1,156	4,829		25
26	Insurance-Prop.Liab.Malpractice			11,575	11,575		11,575	400	11,975		26
27	Other (specify):* Home Off. Ben. All.							7,553	7,553		27
28	TOTAL General Administration	9,750	3,326	179,093	192,169		192,169	3,893	196,062		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	612,371	121,070	237,982	971,423		971,423	5,663	977,086		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 Cisne Rehabilitation & Health Care Center #0047423 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			15,792	15,792		15,792	1,937	17,729			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			6,224	6,224		6,224	14,571	20,795			32
33	Real Estate Taxes			10,373	10,373		10,373	243	10,616			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			3,960	3,960		3,960	232	4,192			35
36	Other (specify):*											36
37	TOTAL Ownership			36,349	36,349		36,349	16,983	53,332			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		42,565		42,565		42,565		42,565			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			19,163	19,163		19,163		19,163			42
43	Other (specify):* Non-allowable Cost		658	15,381	16,039		16,039	(16,039)				43
44	TOTAL Special Cost Centers		43,223	34,544	77,767		77,767	(16,039)	61,728			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	612,371	164,293	308,875	1,085,539		1,085,539	6,607	1,092,146			45

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

Facility Name & ID Number Cisne Rehabilitation & Health Care Center# 0047423

Report Period Beginning:

1/1/2009

Ending:

12/31/2009**VI. ADJUSTMENT DETAIL****A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.****In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(472)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,547)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(311)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(51)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(4,565)	43		24
25	Fund Raising, Advertising and Promotional	(2,505)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg. 5A	(9,108)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (20,559)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	27,166	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 27,166		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 6,607		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4
		Yes	No	Amount	Reference
38	Medically Necessary Transport.		X	\$	38
39					39
40	Gift and Coffee Shops		X		40
41	Barber and Beauty Shops		X		41
42	Laboratory and Radiology		X		42
43	Prescription Drugs		X		43
44					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY

48		49		50		51		52	
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Cisne Rehabilitation & Health Care Center

ID# 0047423

Report Period Beginning: 1/1/2009

Ending: 12/31/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Disallowed Special Events	(46)	43	1
2	Offset Meals on Wheels Revenue	(3,576)	2	2
3	Offset Miscellaneous Office Supplies Revenue	(161)	21	3
4	Resident Flowers	(118)	43	4
5	Labs-Part A	(4,761)	43	5
6	X-Rays-Part A	(446)	43	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
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41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(9,108)		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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 1,917	\$ 1,917	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	43	43	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	18	18	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	189	189	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	928	928	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	346	346	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	1,160	1,160	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%	143	143	10
11	V	17 Administrative	62,000	Petersen Health Care, Inc.	100.00%	30,496	(31,504)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	2,687	2,687	12
13	V							13
14	Total		\$ 62,000			\$ 37,927	\$ * (24,073)	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%	\$ 749	\$	749	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	19,544		19,544	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	199		199	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	62		62	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	963		963	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	400		400	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	5,246		5,246	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	1,580		1,580	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	2,430		2,430	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	243		243	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%	232		232	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		\$			\$ 31,648	\$ *	31,648	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1 Dietary	\$	Petersen 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%	1,074	1,074	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	15 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	0		23	
24	V	17 Administrative		Petersen Health Operations, LLC	100.00%	0		24	
25	V	19 Professional Services		Petersen Health Operations, LLC	100.00%	748	748	25	
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Operations, LLC	100.00%	779	779	26	
27	V	21 Clerical and General Office		Petersen Health Operations, LLC	100.00%	1,681	1,681	27	
28	V	22 Employee Benefits & Payroll		Petersen Health Operations, LLC	100.00%	0		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%	193	193	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%	2,307	2,307	33	
34	V	30 Depreciation		Petersen Health Operations, LLC	100.00%	668	668	34	
35	V	32 Interest		Petersen Health Operations, LLC	100.00%	12,141	12,141	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		\$			\$ 19,591	\$ *	19,591	39

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

Facility Name & ID Number Cisne Rehabilitation & Health Care Center # 0047423 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	157,867	0.43	0.71	Salary	\$ 1,246	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	\$ 1,246		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 Cisne Rehabilitation & Health Care Center # 0047423 Report Period Beginning: 1/1/2009 Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,493,044	75	\$ 261,102	\$ 259,584	10,960	\$ 1,917	1
2	2	Food	Resident Days	1,493,044	75	5,864	0	10,960	43	2
3	3	Housekeeping	Resident Days	1,493,044	75	2,458	0	10,960	18	3
4	4	Laundry	Resident Days	1,493,044	75	0	0	10,960	0	4
5	5	Utilities	Resident Days	1,493,044	75	25,776	0	10,960	189	5
6	6	Maintenance	Resident Days	1,493,044	75	126,463	107,810	10,960	928	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	47,148	0	10,960	346	7
8	10	Nursing and Medical Records	Resident Days	1,493,044	75	158,020	151,697	10,960	1,160	8
9	10A	Therapy	Resident Days	1,493,044	75	0	0	10,960	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	19,462	0	10,960	143	10
11	17	Administrative	Resident Days	1,493,044	75	3,315,953	3,315,953	10,960	30,496	11
12	19	Professional Services	Resident Days	1,493,044	75	366,089	0	10,960	2,687	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,493,044	75	102,022	0	10,960	749	13
14	21	Clerical and General Office	Resident Days	1,493,044	75	2,662,394	2,253,243	10,960	19,544	14
15	23	Inservice Training & Education	Resident Days	1,493,044	75	27,176	0	10,960	199	15
16	24	Travel and Seminar	Resident Days	1,493,044	75	8,381	0	10,960	62	16
17	25	Other Admin. Staff Transport.	Resident Days	1,493,044	75	131,200	0	10,960	963	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,493,044	75	54,425	0	10,960	400	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	714,650	0	10,960	5,246	19
20	30	Depreciation	Resident Days	1,493,044	75	215,197	0	10,960	1,580	20
21	32	Interest	Resident Days	1,493,044	75	330,981	0	10,960	2,430	21
22	33	Real Estate Taxes	Resident Days	1,493,044	75	33,065	0	10,960	243	22
23	34	Rent-Facility and Grounds	Resident Days	1,493,044	75	0	0	10,960	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,493,044	75	31,635	0	10,960	232	24
25	TOTALS					\$ 8,639,461	\$ 6,088,287		\$ 69,575	25

Facility Name & ID Number Cisne Rehabilitation & Health Care Center # 0047423 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 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

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	399,145	21	\$	\$	10,960	\$	1
2	2	Food	Resident Days	399,145	21			10,960		2
3	3	Housekeeping	Resident Days	399,145	21			10,960		3
4	4	Laundry	Resident Days	399,145	21			10,960		4
5	5	Utilities	Resident Days	399,145	21			10,960		5
6	6	Maintenance	Resident Days	399,145	21	39,101		10,960	1,074	6
7	7	Mgmt. Allocation of Benefits	Resident Days	399,145	21			10,960		7
8	10	Nursing and Medical Records	Resident Days	399,145	21			10,960		8
9	12	Social Services	Resident Days	399,145	21			10,960		9
10	17	Administrative	Resident Days	399,145	21			10,960		10
11	19	Professional Services	Resident Days	399,145	21	27,247		10,960	748	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	399,145	21	28,366		10,960	779	12
13	21	Clerical and General Office	Resident Days	399,145	21	61,225		10,960	1,681	13
14	22	Employee Benefits & Payroll	Resident Days	399,145	21			10,960		14
15	23	Inservice Training & Education	Resident Days	399,145	21			10,960		15
16	24	Travel and Seminar	Resident Days	399,145	21			10,960		16
17	25	Other Admin. Staff Transport.	Resident Days	399,145	21	7,018		10,960	193	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	399,145	21			10,960		18
19	27	Mgmt. Allocation of Benefits	Resident Days	399,145	21	84,024		10,960	2,307	19
20	30	Depreciation	Resident Days	399,145	21	24,325		10,960	668	20
21	32	Interest	Resident Days	399,145	21	442,158		10,960	12,141	21
22	33	Real Estate Taxes	Resident Days	399,145	21			10,960		22
23	34	Rent-Facility and Grounds	Resident Days	399,145	21			10,960		23
24	35	Rent-Equipment & Vehicles	Resident Days	399,145	21			10,960		24
25	TOTALS					\$ 713,464	\$		\$ 19,591	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	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	Varies	1/19/07	\$ 125,000	\$ 121,141	9/20/2010	Varies	\$ 6,224	1							
2												2							
3												3							
4							Home Office Allocation-PHC				2,430	4							
5							Home Office Allocation-PHO				12,141	5							
Working Capital																			
6												6							
7												7							
8												8							
9	TOTAL Facility Related						\$ 125,000	\$ 121,141			\$ 20,795	9							
B. Non-Facility Related*																			
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$	14							
15	TOTALS (line 9+line14)						\$ 125,000	\$ 121,141			\$ 20,795	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: 9,413 B. General Construction Type: Exterior Brick Veneer 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>75,359</u>	<u>2005</u>	<u>\$ 9,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	75,359		\$ 9,000	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	35	2005	1970	\$ 176,500	\$	25	\$ 7,060	\$ 7,060	\$ 31,770
5									
6									
7									
8									
Improvement Type**									
9	Original Land Improvements		2005	10,000		15	667	667	3,001
10	Waterline		2005	1,634		15	109	109	490
11	Carpet		2006	1,269		5	254	254	889
12	Gutter		2006	2,750		25	110	110	385
13	Sewer Line		2007	3,500		20	175	175	438
14	Condenser Unit		2009	5,018		7	358	358	358
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27	Land Improvements Booked				1,009			(1,009)	
28	Building Booked				7,090			(7,090)	
29	Building Improvement Booked				722			(722)	
30									
31									
32	2009-Home Office Allocation-Land Improvements			361			23	23	
33	2009-Home Office Allocation-Building Improvements			5,388			129	129	
34									
35									
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								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 206,420	\$ 8,821		\$ 8,885	\$ 64	\$ 37,331	70

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

Facility Name & ID Number Cisne Rehabilitation & Health Care Center

0047423

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 43,438	\$ 5,876	\$ 6,157	\$ 281	5-10 yrs.	\$ 27,042	71
72	Current Year Purchases	8,775	1,095	439	(656)	10 yrs.	439	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			2,248	2,248			74
75	TOTALS	\$ 52,213	\$ 6,971	\$ 8,844	\$ 1,873		\$ 27,481	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	2		
	Reference	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)	\$ 267,633	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 15,792	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 17,729	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,937	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 64,812	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: \$ 4,192 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.

Cisne Rehabilitation & Health Care Center
0047423
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	\$	1,031
Dishwasher		708
Copier		2,221
Home Office Allocation		232
		<u>4,192</u>
		<u><u>4,192</u></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? <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. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></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	\$	865	\$ 12,968	\$	865	\$ 12,968	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		43	645		43	645	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		1,118	16,770	120	1,118	16,890	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				42,565		42,565	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			\$	2,026	\$ 30,383	\$ 42,685	2,026	\$ 73,068	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 **Cisne Rehabilitation & Health Care Center**

0047423

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

Ending: **12/31/2009**

XV. BALANCE SHEET - Unrestricted Operating Fund.

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

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ (50,327)	\$ (50,327)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>N/A</u>)	124,721	124,721	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	17,447	17,447	6
7	Other Prepaid Expenses	4,944	4,944	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	11,000	11,000	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 107,785	\$ 107,785	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	24,134	9,000	13
14	Buildings, at Historical Cost	176,500	181,888	14
15	Leasehold Improvements, at Historical Cost	9,037	24,532	15
16	Equipment, at Historical Cost	52,213	52,213	16
17	Accumulated Depreciation (book methods)	(62,120)	(64,812)	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)	\$ 199,764	\$ 202,821	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 307,549	\$ 310,606	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 111,746	\$ 111,746	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	12,478	12,478	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,888	1,888	31
32	Accrued Real Estate Taxes(Sch.IX-B)	10,200	10,200	32
33	Accrued Interest Payable	543	543	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Payroll Withholdings</u>	27,048	27,048	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 163,903	\$ 163,903	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	121,141	121,141	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)	\$ 121,141	\$ 121,141	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 285,044	\$ 285,044	46
47	TOTAL EQUITY(page 18, line 24)	\$ 22,505	\$ 25,562	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 307,549	\$ 310,606	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (361,968)	1
2	Restatements (describe):		2
3	2008 Bad Debt Allowance Entered After CR Completion	(5,000)	3
4	Rounding	(1)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (366,969)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	389,474	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)	\$ 389,474	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)	\$ 22,505	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Cisne Rehabilitation & Health Care Center# 0047423Report 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	\$ 1,226,995	1
2	Discounts and Allowances for all Levels	(42,909)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,184,086	3
B. Ancillary Revenue			
4	Day Care	1,934	4
5	Other Care for Outpatients		5
6	Therapy	198,484	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 200,418	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	4,048	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	73,704	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	5,759	20
21	Other Medical Services	1,660	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 85,171	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	161	28
28a	Gain on Property/Equipment	5,177	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 5,338	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,475,013	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	257,881	31
32	Health Care	521,373	32
33	General Administration	192,169	33
B. Capital Expense			
34	Ownership	36,349	34
C. Ancillary Expense			
35	Special Cost Centers	58,604	35
36	Provider Participation Fee	19,163	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,085,539	40
41	Income before Income Taxes (line 30 minus line 40)**	389,474	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 389,474	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 **Cisne Rehabilitation & Health Care Center**

0047423

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

Ending:

12/31/2009

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,080	2,080	47,362	\$ 22.77	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,187	6,354	119,845	18.86	3
4	Licensed Practical Nurses	3,176	3,398	50,046	14.73	4
5	CNAs & Orderlies	21,320	21,791	185,042	8.49	5
6	CNA Trainees					6
7	Licensed Therapist	180	224	14,083	62.87	7
8	Rehab/Therapy Aides	411	537	16,300	30.35	8
9	Activity Director	2,080	2,080	21,358	10.27	9
10	Activity Assistants					10
11	Social Service Workers	2080	2,080	20,659	9.93	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	19,761	9.50	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,830	6,908	53,822	7.79	15
16	Dishwashers					16
17	Maintenance Workers	235	236	2,837	12.02	17
18	Housekeepers	3,472	3,606	28,730	7.97	18
19	Laundry	1,852	1,982	15,887	8.02	19
20	Administrator	2,080	2,080	39,000	18.75	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					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>	865	869	6,889	7.93	33
34	TOTAL (lines 1 - 33)	54,928	56,305	\$ 641,621 *	\$ 11.40	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 8,400	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)	\$ 9,000		49

C. CONTRACT NURSES

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

Cisne Rehabilitation & Health Care Center

0047423

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)		4,901

Home Office Allocation

Heyl, Royster, Voelker & Allen	Legal	(8)
GoffWilson, P.A.	Legal	24
Jackson Lewis	Legal	193
Peter Gartelos	Legal	19
Misc.	Legal	17
Ginoli & Company	Accountants	1,160
Miscellaneous Vendors	Computer Services	18
Emdeon Business Services	Computer Services	8
Advanced Answers on Demand	Computer Services	1,033
Access 2 Go	Computer Services	99
Ivans	Computer Services	54
Kemper Technology	Computer Services	281
VisionShare	Computer Services	87
MediFax	Computer Services	36
LogmeIn	Computer Services	15
Charter Communications	Computer Services	1
Simple LTC	Computer Services	238
Miscellaneous Vendors	Miscellaneous	160
Total (agree to Schedule V, line 19, column 8)		<u>8,336</u>

Facility Name & ID Number Cisne Rehabilitation & Health Care Center# 0047423Report 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. \$ 5,672 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. \$ 19,163
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. \$ 4,048
- (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.