

Facility Name & ID Number Decatur Rehabilitation & Health Care Center

0047449 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	58	Intermediate (ICF)	58	21,170	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	58	TOTALS	58	21,170	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	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	13,027	888	382	14,297	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,027	888	382	14,297	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.53%

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

ACCRAUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number Decatur Rehabilitation & Health Care Center # 0047449 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	85,951	9,826		95,777		95,777	2,500	98,277		1
2	Food Purchase		77,730		77,730		77,730	(96)	77,634		2
3	Housekeeping	88,510	20,697		109,207		109,207	24	109,231		3
4	Laundry	16,434	11,783		28,217		28,217		28,217		4
5	Heat and Other Utilities			38,840	38,840		38,840	247	39,087		5
6	Maintenance	29,748	12,220	18,907	60,875		60,875	2,612	63,487		6
7	Other (specify):* <u>Home Off. Ben. All.</u>							451	451		7
8	TOTAL General Services	220,643	132,256	57,747	410,646		410,646	5,738	416,384		8
	B. Health Care and Programs										
9	Medical Director			15,000	15,000		15,000		15,000		9
10	Nursing and Medical Records	548,254	35,969	6,620	590,843		590,843	1,100	591,943		10
10a	Therapy			213	213		213		213		10a
11	Activities	25,946	706	279	26,931		26,931		26,931		11
12	Social Services	9,690	81		9,771		9,771		9,771		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Off. Ben. All.</u>							186	186		15
16	TOTAL Health Care and Programs	583,890	36,756	22,112	642,758		642,758	1,286	644,044		16
	C. General Administration										
17	Administrative	8,624		93,000	101,624		101,624	(50,125)	51,499		17
18	Directors Fees										18
19	Professional Services			5,141	5,141		5,141	4,482	9,623		19
20	Dues, Fees, Subscriptions & Promotions			7,961	7,961		7,961	1,448	9,409		20
21	Clerical & General Office Expenses	16,638	3,479	6,692	26,809		26,809	27,343	54,152		21
22	Employee Benefits & Payroll Taxes			133,014	133,014		133,014		133,014		22
23	Inservice Training & Education							260	260		23
24	Travel and Seminar							80	80		24
25	Other Admin. Staff Transportation			6,071	6,071		6,071	1,507	7,578		25
26	Insurance-Prop.Liab.Malpractice			20,577	20,577		20,577	521	21,098		26
27	Other (specify):* <u>Home Off. Ben. All.</u>							9,853	9,853		27
28	TOTAL General Administration	25,262	3,479	272,456	301,197		301,197	(4,631)	296,566		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	829,795	172,491	352,315	1,354,601		1,354,601	2,393	1,356,994		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 Decatur Rehabilitation & Health Care Center #0047449 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			26,859	26,859		26,859	2,566	29,425			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			16,182	16,182		16,182	17,135	33,317			32
33	Real Estate Taxes			23,281	23,281		23,281	317	23,598			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			2,873	2,873		2,873	303	3,176			35
36	Other (specify):*											36
37	TOTAL Ownership			69,195	69,195		69,195	20,321	89,516			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		7,759		7,759		7,759		7,759			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			31,755	31,755		31,755		31,755			42
43	Other (specify):* Non-allowable Cost	14,913	299	29,684	44,896		44,896	(44,896)				43
44	TOTAL Special Cost Centers	14,913	8,058	61,439	84,410		84,410	(44,896)	39,514			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	844,708	180,549	482,949	1,508,206		1,508,206	(22,182)	1,486,024			45

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

Decatur Rehabilitation & Health Care Center

ID# 0047449

Report Period Beginning: 1/1/2009

Ending: 12/31/2009

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Labs-Part A	\$ 107	43	1
2	X-Rays-Part A	(864)	43	2
3	Offset Miscellaneous Nursing Supplies Revenue	(413)	10	3
4	Disallowed Special Events	(268)	43	4
5	Offset Miscellaneous Office Supplies Revenue	(344)	21	5
6	Offset Chamber of Commerce Dues	(545)	20	6
7	Resident Flowers	(107)	43	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
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31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(2,434)		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%	\$ 2,500	\$ 2,500	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	56	56	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	24	24	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	247	247	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	1,211	1,211	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	451	451	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	1,513	1,513	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%	186	186	10
11	V	17 Administrative	93,000	Petersen Health Care, Inc.	100.00%	42,875	(50,125)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	3,506	3,506	12
13	V							13
14	Total		\$ 93,000			\$ 52,569	\$ * (40,431)	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%	\$ 977	\$	977	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	25,494		25,494	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	260		260	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	80		80	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	1,256		1,256	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	521		521	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	6,843		6,843	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	2,061		2,061	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	3,169		3,169	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	317		317	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%	303		303	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		\$			\$ 41,281	\$ *	41,281	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%	1,401	1,401	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%	976	976	25	
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Operations, LLC	100.00%	1,016	1,016	26	
27	V	21 Clerical and General Office		Petersen Health Operations, LLC	100.00%	2,193	2,193	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%	251	251	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%	3,010	3,010	33	
34	V	30 Depreciation		Petersen Health Operations, LLC	100.00%	871	871	34	
35	V	32 Interest		Petersen Health Operations, LLC	100.00%	15,838	15,838	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		\$			\$ 25,556	\$ *	25,556	39

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

Facility Name & ID Number Decatur Rehabilitation & Health Care Cente # 0047449 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	157,488	0.56	0.93	Salary	\$ 1,625	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	\$ 1,625		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 Decatur Rehabilitation & Health Care Center # 0047449 Report Period Beginning: 1/1/2009 Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,493,044	75	\$ 261,102	\$ 259,584	14,297	\$ 2,500	1
2	2	Food	Resident Days	1,493,044	75	5,864	0	14,297	56	2
3	3	Housekeeping	Resident Days	1,493,044	75	2,458	0	14,297	24	3
4	4	Laundry	Resident Days	1,493,044	75	0	0	14,297	0	4
5	5	Utilities	Resident Days	1,493,044	75	25,776	0	14,297	247	5
6	6	Maintenance	Resident Days	1,493,044	75	126,463	107,810	14,297	1,211	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	47,148	0	14,297	451	7
8	10	Nursing and Medical Records	Resident Days	1,493,044	75	158,020	151,697	14,297	1,513	8
9	10A	Therapy	Resident Days	1,493,044	75	0	0	14,297	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	19,462	0	14,297	186	10
11	17	Administrative	Resident Days	1,493,044	75	3,315,953	3,315,953	14,297	42,875	11
12	19	Professional Services	Resident Days	1,493,044	75	366,089	0	14,297	3,506	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,493,044	75	102,022	0	14,297	977	13
14	21	Clerical and General Office	Resident Days	1,493,044	75	2,662,394	2,253,243	14,297	25,494	14
15	23	Inservice Training & Education	Resident Days	1,493,044	75	27,176	0	14,297	260	15
16	24	Travel and Seminar	Resident Days	1,493,044	75	8,381	0	14,297	80	16
17	25	Other Admin. Staff Transport.	Resident Days	1,493,044	75	131,200	0	14,297	1,256	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,493,044	75	54,425	0	14,297	521	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	714,650	0	14,297	6,843	19
20	30	Depreciation	Resident Days	1,493,044	75	215,197	0	14,297	2,061	20
21	32	Interest	Resident Days	1,493,044	75	330,981	0	14,297	3,169	21
22	33	Real Estate Taxes	Resident Days	1,493,044	75	33,065	0	14,297	317	22
23	34	Rent-Facility and Grounds	Resident Days	1,493,044	75	0	0	14,297	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,493,044	75	31,635	0	14,297	303	24
25	TOTALS					\$ 8,639,461	\$ 6,088,287		\$ 93,850	25

Facility Name & ID Number Decatur Rehabilitation & Health Care Center# 0047449

Report Period Beginning:

1/1/2009Ending: 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	\$	\$	14,297	\$	1
2	2	Food	Resident Days	399,145	21			14,297		2
3	3	Housekeeping	Resident Days	399,145	21			14,297		3
4	4	Laundry	Resident Days	399,145	21			14,297		4
5	5	Utilities	Resident Days	399,145	21			14,297		5
6	6	Maintenance	Resident Days	399,145	21	39,101		14,297	1,401	6
7	7	Mgmt. Allocation of Benefits	Resident Days	399,145	21			14,297		7
8	10	Nursing and Medical Records	Resident Days	399,145	21			14,297		8
9	12	Social Services	Resident Days	399,145	21			14,297		9
10	17	Administrative	Resident Days	399,145	21			14,297		10
11	19	Professional Services	Resident Days	399,145	21	27,247		14,297	976	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	399,145	21	28,366		14,297	1,016	12
13	21	Clerical and General Office	Resident Days	399,145	21	61,225		14,297	2,193	13
14	22	Employee Benefits & Payroll	Resident Days	399,145	21			14,297		14
15	23	Inservice Training & Education	Resident Days	399,145	21			14,297		15
16	24	Travel and Seminar	Resident Days	399,145	21			14,297		16
17	25	Other Admin. Staff Transport.	Resident Days	399,145	21	7,018		14,297	251	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	399,145	21			14,297		18
19	27	Mgmt. Allocation of Benefits	Resident Days	399,145	21	84,024		14,297	3,010	19
20	30	Depreciation	Resident Days	399,145	21	24,325		14,297	871	20
21	32	Interest	Resident Days	399,145	21	442,158		14,297	15,838	21
22	33	Real Estate Taxes	Resident Days	399,145	21			14,297		22
23	34	Rent-Facility and Grounds	Resident Days	399,145	21			14,297		23
24	35	Rent-Equipment & Vehicles	Resident Days	399,145	21			14,297		24
25	TOTALS					\$ 713,464	\$		\$ 25,556	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	1/19/2007	\$ 325,000	\$ 315,195	12/31/13	Varies	\$ 16,182	1							
2												2							
3							Interest Income Offset				(1,872)	3							
4							Home Office Allocation-PHC				3,169	4							
5							Home Office Allocation-PHO				15,838	5							
Working Capital																			
6												6							
7												7							
8												8							
9	TOTAL Facility Related						\$ 325,000	\$ 315,195			\$ 33,317	9							
B. Non-Facility Related*																			
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$	14							
15	TOTALS (line 9+line14)						\$ 325,000	\$ 315,195			\$ 33,317	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: 8,653 B. General Construction Type: Exterior Brick Frame Concrete 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>43,560</u>	<u>2005</u>	<u>\$ 37,500</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	43,560		\$ 37,500	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	58	2005	1970	\$ 275,500	\$	25	\$ 11,020	\$ 11,020	\$ 49,590
5									
6									
7									
8									
	Improvement Type**								
9	Original Land Improvements	2005		10,000		15	667	667	3,001
10	Sidewalks	2006		2,311		15	154	154	539
11	Remodel Nurses Station	2007		6,718		15	448	448	1,120
12	Water Heater-100 Gallon	2008		5,604		5	1,120	1,120	1,680
13	Painting-Exterior	2009		4,908		15	164	164	164
14	Sprinkler System Installation	2009		11,774		15	392	392	392
15	Windows Installation-(41)	2009		11,234		15	374	374	374
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27	Land Improvements Booked				821			(821)	
28	Building Booked				11,069			(11,069)	
29	Building Improvement Booked				1,769			(1,769)	
30									
31									
32	2009-Home Office Allocation-Land Improvements			470			30	30	
33	2009-Home Office Allocation-Building Improvements			7,028			169	169	
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)	\$	335,547	\$	13,659	\$	14,538	\$	879	\$	56,860	70

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

Facility Name & ID Number Decatur Rehabilitation & Health Care Center

0047449

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	\$ 88,360	\$ 12,077	\$ 11,505	\$ (572)	5-10 yrs.	\$ 49,009	71
72	Current Year Purchases	9,007	1,123	450	(673)	10 yrs.	450	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			2,932	2,932			74
75	TOTALS	\$ 97,367	\$ 13,200	\$ 14,887	\$ 1,687		\$ 49,459	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)	\$ 470,414	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 26,859	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 29,425	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,566	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 106,319	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	Non-Care Vacant Land	\$ 75,000	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 75,000	\$	\$	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: \$ 3,176 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			N/A		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.

Decatur Rehabilitation & Health Care Center

0047449

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	\$	857
Dishwasher		708
Maintenance Equipment		102
Copier		1,206
Home Office Allocation		303
		<u>3,176</u>

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units						Cost
					Units	Cost					
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1	
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		14	213		14	213	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist		hrs							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				7,759		7,759	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			\$	14	\$ 213	\$ 7,759	14	\$ 7,972	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 **Decatur Rehabilitation & Health Care Center**

0047449

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*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 345,525	\$ 345,525	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>N/A</u>)	211,357	211,357	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	29,412	29,412	6
7	Other Prepaid Expenses	7,380	7,380	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Prepaid Management Fees</u>	30,000	30,000	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 623,674	\$ 623,674	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	124,811	37,500	13
14	Buildings, at Historical Cost	275,500	282,528	14
15	Leasehold Improvements, at Historical Cost	40,238	53,019	15
16	Equipment, at Historical Cost	97,367	97,367	16
17	Accumulated Depreciation (book methods)	(103,459)	(106,319)	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): <u>Non-Care Land</u>		75,000	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 434,457	\$ 439,095	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,058,131	\$ 1,062,769	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 168,002	\$ 168,002	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	15,938	15,938	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,894	2,894	31
32	Accrued Real Estate Taxes(Sch.IX-B)	24,000	24,000	32
33	Accrued Interest Payable	1,411	1,411	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Payroll Withholdings</u>	37,589	37,589	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 249,834	\$ 249,834	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	315,195	315,195	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)	\$ 315,195	\$ 315,195	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 565,029	\$ 565,029	46
47	TOTAL EQUITY(page 18, line 24)	\$ 493,102	\$ 497,740	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,058,131	\$ 1,062,769	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 349,798	1
2	Restatements (describe):		2
3	Rounding	(2)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 349,796	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	143,306	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)	\$ 143,306	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)	\$ 493,102	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **Decatur Rehabilitation & Health Care Center**# **0047449**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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 1,648,731	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,648,731	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	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	152	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	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 152	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,872	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,872	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Revenue</u>	757	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 757	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,651,512	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	410,646	31
32	Health Care	642,758	32
33	General Administration	301,197	33
B. Capital Expense			
34	Ownership	69,195	34
C. Ancillary Expense			
35	Special Cost Centers	52,655	35
36	Provider Participation Fee	31,755	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,508,206	40
41	Income before Income Taxes (line 30 minus line 40)**	143,306	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 143,306	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 **Decatur Rehabilitation & Health Care Center**

0047449

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	\$ 61,458	\$ 29.55	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,498	2,509	52,804	21.05	3
4	Licensed Practical Nurses	8,256	8,392	159,061	18.95	4
5	CNAs & Orderlies	24,738	25,156	245,578	9.76	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,993	2,025	25,946	12.81	9
10	Activity Assistants					10
11	Social Service Workers	716	740	9,690	13.09	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	25,710	12.36	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,021	7,377	60,241	8.17	15
16	Dishwashers					16
17	Maintenance Workers	1,963	2,082	29,748	14.29	17
18	Housekeepers	9,478	9,478	88,510	9.34	18
19	Laundry	2,084	2,084	16,434	7.89	19
20	Administrator	1,693	1,845	49,874	27.03	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,304	1,402	16,638	11.87	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: Marketing	969	969	14,913	15.39	32
33	Other(specify) Care Plan Coord.	1,357	1,524	29,353	19.26	33
34	TOTAL (lines 1 - 33)	68,230	69,743	\$ 885,958 *	\$ 12.70	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	15,000	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) Psychologist	9 visits	975	10(3)	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 16,575		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	57	2,089	10(3)	51
52	Certified Nurse Assistants/Aides	121	2,717	10(3)	52
53	TOTAL (lines 50 - 52)	178	\$ 4,806		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	
Lynnette Green	Administrator	0	\$ 6,121	Workers' Compensation Insurance	\$ 28,353	IDPH License Fee	\$ 995	
Christopher White	Administrator	0	43,753	Unemployment Compensation Insurance	19,050	Advertising: Employee Recruitment	3,011	
				FICA Taxes	63,464	Health Care Worker Background Check (Indicate # of checks performed)		
				Employee Health Insurance	20,761	<u>Patient Background Checks</u>	<u>106</u> 1,060	
				Employee Meals		Miscellaneous Licenses & Permits	850	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Dues & Subscriptions	545	
				<u>Employee Relations</u>	<u>1,386</u>	IHCA Dues	1,500	
						Home Office Allocation	1,993	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 49,874			Less: Public Relations Expense	(545)	
B. Administrative - Other						Non-allowable advertising	()	
Description			Amount			Yellow page advertising	()	
<u>Management Fees-See Page 6, Eliminated on P 3, C 7</u>			\$ 93,000					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 93,000					
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
AT&T	Computer Services		\$ 660				Out-of-State Travel	\$
E-Health Data Solutions	Computer Services		2,700					
LTC Solutions	Computer Services		1,700					
SimpleLTC, Inc.	Computer Services		81	N/A			In-State Travel	
							Seminar Expense	
							<u>Home Office Allocation</u>	80
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 5,141	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 80

* Attach copy of IMRF notifications

**See instructions.

Decatur Rehabilitation & Health Care Center

0047449

Period Beginning 1/1/2009

Period End 12/31/2009

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		5,141

Home Office Allocation

Heyl, Royster, Voelker & Allen	Legal	(11)
GoffWilson, P.A.	Legal	32
Jackson Lewis	Legal	251
Peter Gartelos	Legal	24
Misc.	Legal	22
Ginoli & Company	Accountants	1,512
Miscellaneous Vendors	Computer Services	23
Emdeon Business Services	Computer Services	11
Advanced Answers on Demand	Computer Services	1,347
Access 2 Go	Computer Services	129
Ivans	Computer Services	70
Kemper Technology	Computer Services	366
VisionShare	Computer Services	114
MediFax	Computer Services	46
LogmeIn	Computer Services	20
Charter Communications	Computer Services	1
Simple LTC	Computer Services	311
Miscellaneous Vendors	Miscellaneous	214
Total (agree to Schedule V, line 19, column 8)		<u>9,623</u>

Facility Name & ID Number Decatur Rehabilitation & Health Care Center# 0047449Report 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. \$ 6,598 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. \$ 31,755
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. \$ 152
- (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.