

Facility Name & ID Number Effingham Rehabilitation & Health Care Center

0047159 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	62	Skilled (SNF)	62	22,630	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	62	TOTALS	62	22,630	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		Medicaid Recipient	Private Pay	Other		
8	SNF	10,909	3,884	1,443	16,236	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,909	3,884	1,443	16,236	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.75%

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 5/1/05

J. Was the facility purchased or leased after January 1, 1978?
YES Date 5/1/05 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 62 and days of care provided 1,440

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 Effingham Rehabilitation & Health Care Cen # 0047159 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	121,459	10,896		132,355		132,355	2,839	135,194		1
2	Food Purchase		86,753		86,753		86,753	(708)	86,045		2
3	Housekeeping	43,747	10,681		54,428		54,428	27	54,455		3
4	Laundry	44,206	16,369		60,575		60,575		60,575		4
5	Heat and Other Utilities			75,270	75,270		75,270	280	75,550		5
6	Maintenance	29,217	8,825	11,521	49,563		49,563	1,375	50,938		6
7	Other (specify):* <u>Home Off. Ben. All.</u>							513	513		7
8	TOTAL General Services	238,629	133,524	86,791	458,944		458,944	4,326	463,270		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	747,326	80,590	6,485	834,401		834,401	1,718	836,119		10
10a	Therapy	170,990	265		171,255		171,255		171,255		10a
11	Activities	19,140	419	283	19,842		19,842		19,842		11
12	Social Services	25,481	12		25,493		25,493		25,493		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Off. Ben. All.</u>							212	212		15
16	TOTAL Health Care and Programs	962,937	81,286	12,768	1,056,991		1,056,991	1,930	1,058,921		16
	C. General Administration										
17	Administrative	13,000		84,000	97,000		97,000	(43,071)	53,929		17
18	Directors Fees										18
19	Professional Services			5,059	5,059		5,059	5,787	10,846		19
20	Dues, Fees, Subscriptions & Promotions			8,181	8,181		8,181	2,193	10,374		20
21	Clerical & General Office Expenses	23,802	5,630	11,120	40,552		40,552	33,509	74,061		21
22	Employee Benefits & Payroll Taxes			158,726	158,726		158,726	251	158,977		22
23	Inservice Training & Education			400	400		400	296	696		23
24	Travel and Seminar							91	91		24
25	Other Admin. Staff Transportation			2,060	2,060		2,060	1,427	3,487		25
26	Insurance-Prop.Liab.Malpractice			21,439	21,439		21,439	592	22,031		26
27	Other (specify):* <u>Home Off. Ben. All.</u>							7,771	7,771		27
28	TOTAL General Administration	36,802	5,630	290,985	333,417		333,417	8,846	342,263		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,238,368	220,440	390,544	1,849,352		1,849,352	15,102	1,864,454		29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	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			53,646	53,646		53,646	5,501	59,147			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			52,740	52,740		52,740	15,622	68,362			32
33	Real Estate Taxes			34,555	34,555		34,555	360	34,915			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			16,109	16,109		16,109	344	16,453			35
36	Other (specify):*											36
37	TOTAL Ownership			157,050	157,050		157,050	21,827	178,877			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		70,533		70,533		70,533		70,533			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			33,945	33,945		33,945		33,945			42
43	Other (specify):* Non-allowable Cost	3,412	790	62,118	66,320		66,320	(66,320)				43
44	TOTAL Special Cost Centers	3,412	71,323	96,063	170,798		170,798	(66,320)	104,478			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,241,780	291,763	643,657	2,177,200		2,177,200	(29,391)	2,147,809			45

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

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	(772)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,815)	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	180	30		9
10	Interest and Other Investment Income	(2,744)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(46)	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 Retainer				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(44,008)	43		24
25	Fund Raising, Advertising and Promotional	(7,928)	43		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg. 5A	(11,408)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (70,541)		\$	30

BHF USE ONLY						
48		49		50		51
						52

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
	Amortization of Organization & Pre-Operating Expense			
33				33
	Adjustments for Related Organization Costs (Schedule VII)	41,150	Various	34
34				
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 41,150		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (29,391)		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

Effingham Rehabilitation & Health Care Center

ID# 0047159

Report Period Beginning: 1/1/2009

Ending: 12/31/2009

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Labs-Part A	\$ (8,348)	43	1
2	X-Rays-Part A	(1,263)	43	2
3	Offset Miscellaneous Office Supplies Revenue	(80)	21	3
4	Resident Flowers	(671)	43	4
5	Disallowed Special Events	(241)	43	5
6	Disallowed Chamber of Commerce Dues	(805)	20	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(11,408)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Effingham Rehabilitation & Health Care Center# 0047159

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	2,839	0	0	0	0	0	0	0	0	0	2,839	1
2	Food Purchase	(772)	64	0	0	0	0	0	0	0	0	0	(708)	2
3	Housekeeping	0	27	0	0	0	0	0	0	0	0	0	27	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	280	0	0	0	0	0	0	0	0	0	280	5
6	Maintenance	0	1,375	0	0	0	0	0	0	0	0	0	1,375	6
7	Other (specify):*	0	513	0	0	0	0	0	0	0	0	0	513	7
8	TOTAL General Services	(772)	5,098	0	0	0	0	0	0	0	0	0	4,326	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	1,718	0	0	0	0	0	0	0	0	0	1,718	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	212	0	0	0	0	0	0	0	0	0	212	15
16	TOTAL Health Care and Programs	0	1,930	0	0	0	0	0	0	0	0	0	1,930	16
	C. General Administration													
17	Administrative	0	(43,071)	0	0	0	0	0	0	0	0	0	(43,071)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	3,981	0	1,806	0	0	0	0	0	0	0	5,787	19
20	Fees, Subscriptions & Promotions	(805)	0	1,109	1,889	0	0	0	0	0	0	0	2,193	20
21	Clerical & General Office Expenses	(80)	0	28,952	4,637	0	0	0	0	0	0	0	33,509	21
22	Employee Benefits & Payroll Taxes	0	0	0	251	0	0	0	0	0	0	0	251	22
23	Inservice Training & Education	0	0	296	0	0	0	0	0	0	0	0	296	23
24	Travel and Seminar	0	0	91	0	0	0	0	0	0	0	0	91	24
25	Other Admin. Staff Transportation	0	0	1,427	0	0	0	0	0	0	0	0	1,427	25
26	Insurance-Prop.Liab.Malpractice	0	0	592	0	0	0	0	0	0	0	0	592	26
27	Other (specify):*	0	0	7,771	0	0	0	0	0	0	0	0	7,771	27
28	TOTAL General Administration	(885)	(39,090)	40,238	8,583	0	8,846	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,657)	(32,062)	40,238	8,583	0	15,102	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Effingham Rehabilitation & Health Care Center# 0047159

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	180	0	2,340	2,981	0	0	0	0	0	0	0	5,501	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,744)	0	3,599	14,767	0	0	0	0	0	0	0	15,622	32
33	Real Estate Taxes	0	0	360	0	0	0	0	0	0	0	0	360	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	344	0	0	0	0	0	0	0	0	344	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(2,564)	0	6,643	17,748	0	21,827	37						
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(66,320)	0	0	0	0	0	0	0	0	0	0	(66,320)	43
44	TOTAL Special Cost Centers	(66,320)	0	0	0	0	0	0	0	0	0	0	(66,320)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(70,541)	(32,062)	46,881	26,331	0	0	0	0	0	0	0	(29,391)	45

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	65	See Attached Schedule 6E		See Attached Sch 6E		
Jifi Jacob	10					
Cindy White	10					
Jacque Whitley	10					
David Petersen	5					

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	1 Dietary	\$	Petersen Health Care, Inc.	65.00%	\$ 2,839	\$ 2,839	1
2	V	2 Food		Petersen Health Care, Inc.	65.00%	64	64	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	65.00%	27	27	3
4	V	4 Laundry		Petersen Health Care, Inc.	65.00%	0		4
5	V	5 Utilities		Petersen Health Care, Inc.	65.00%	280	280	5
6	V	6 Maintenance		Petersen Health Care, Inc.	65.00%	1,375	1,375	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	65.00%	513	513	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	65.00%	1,718	1,718	8
9	V	11 Activities		Petersen Health Care, Inc.	65.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	65.00%	212	212	10
11	V	17 Administrative	84,000	Petersen Health Care, Inc.	65.00%	40,929	(43,071)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	65.00%	3,981	3,981	12
13	V							13
14	Total		\$ 84,000			\$ 51,938	\$ * (32,062)	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.	65.00%	\$ 1,109	\$	1,109	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	65.00%	28,952		28,952	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	65.00%	296		296	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	65.00%	91		91	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	65.00%	1,427		1,427	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	65.00%	592		592	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	65.00%	7,771		7,771	21
22	V	30 Depreciation		Petersen Health Care, Inc.	65.00%	2,340		2,340	22
23	V	32 Interest		Petersen Health Care, Inc.	65.00%	3,599		3,599	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	65.00%	360		360	24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	65.00%	0			25
26	V	35 Rent-Equipment and Vehicles		Petersen Health Care, Inc.	65.00%	344		344	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		\$			\$ 46,881	\$ *	46,881	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 Enterprises, LLC	100.00%	\$ 0	\$	15	
16	V	2 Food		Petersen Health Enterprises, LLC	100.00%	0		16	
17	V	3 Housekeeping		Petersen Health Enterprises, LLC	100.00%	0		17	
18	V	4 Laundry		Petersen Health Enterprises, LLC	100.00%	0		18	
19	V	5 Utilities		Petersen Health Enterprises, LLC	100.00%	0		19	
20	V	6 Maintenance		Petersen Health Enterprises, LLC	100.00%	0		20	
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Enterprises, LLC	100.00%	0		21	
22	V	10 Nursing and Medical Records		Petersen Health Enterprises, LLC	100.00%	0		22	
23	V	15 Mgmt. Allocation of Benefits		Petersen Health Enterprises, LLC	100.00%	0		23	
24	V	17 Administrative		Petersen Health Enterprises, LLC	100.00%	0		24	
25	V	19 Professional Services		Petersen Health Enterprises, LLC	100.00%	1,806	1,806	25	
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Enterprises, LLC	100.00%	1,889	1,889	26	
27	V	21 Clerical and General Office		Petersen Health Enterprises, LLC	100.00%	4,637	4,637	27	
28	V	22 Employee Benefits & Payroll		Petersen Health Enterprises, LLC	100.00%	251	251	28	
29	V	23 Inservice Training & Education		Petersen Health Enterprises, LLC	100.00%	0		29	
30	V	24 Travel and Seminar		Petersen Health Enterprises, LLC	100.00%	0		30	
31	V	25 Other Admin. Staff Transport.		Petersen Health Enterprises, LLC	100.00%	0		31	
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Enterprises, LLC	100.00%	0		32	
33	V	27 Mgmt. Allocation of Benefits		Petersen Health Enterprises, LLC	100.00%	0		33	
34	V	30 Depreciation		Petersen Health Enterprises, LLC	100.00%	2,981	2,981	34	
35	V	32 Interest		Petersen Health Enterprises, LLC	100.00%	14,767	14,767	35	
36	V	33 Real Estate Taxes		Petersen Health Enterprises, LLC	100.00%	0		36	
37	V	34 Rent-Facility and Grounds		Petersen Health Enterprises, LLC	100.00%	0		37	
38	V	35 Rent-Equipment & Vehicles		Petersen Health Enterprises, LLC	100.00%	0		38	
39	Total		\$			\$ 26,331	\$ *	26,331	39

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

Facility Name & ID Number Effingham Rehabilitation & Health Care Ce # 0047159 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	65.00	157,267	0.63	1.05	Salary	\$ 1,846	L17, C7	1
2	Jifi C. Jacob	Owner	Administrative	10.00						N/A	2
3	Cindy S. White	Owner	Administrative	10.00	111,432	0.63	1.05	Salary	1,308	L21, C7	3
4	Jacque Whitley	Owner	Administrative	10.00	104,229	0.65	1.09	Salary	1,223	L10, C7	4
5	David Petersen	Owner	Administrative	5.00						N/A	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 4,377		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 Effingham Rehabilitation & Health Care Center # 0047159 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	16,236	\$ 2,839	1
2	2	Food	Resident Days	1,493,044	75	5,864	0	16,236	64	2
3	3	Housekeeping	Resident Days	1,493,044	75	2,458	0	16,236	27	3
4	4	Laundry	Resident Days	1,493,044	75	0	0	16,236	0	4
5	5	Utilities	Resident Days	1,493,044	75	25,776	0	16,236	280	5
6	6	Maintenance	Resident Days	1,493,044	75	126,463	107,810	16,236	1,375	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	47,148	0	16,236	513	7
8	10	Nursing and Medical Records	Resident Days	1,493,044	75	158,020	151,697	16,236	1,718	8
9	10A	Therapy	Resident Days	1,493,044	75	0	0	16,236	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	19,462	0	16,236	212	10
11	17	Administrative	Resident Days	1,493,044	75	3,315,953	3,315,953	16,236	40,929	11
12	19	Professional Services	Resident Days	1,493,044	75	366,089	0	16,236	3,981	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,493,044	75	102,022	0	16,236	1,109	13
14	21	Clerical and General Office	Resident Days	1,493,044	75	2,662,394	2,253,243	16,236	28,952	14
15	23	Inservice Training & Education	Resident Days	1,493,044	75	27,176	0	16,236	296	15
16	24	Travel and Seminar	Resident Days	1,493,044	75	8,381	0	16,236	91	16
17	25	Other Admin. Staff Transport.	Resident Days	1,493,044	75	131,200	0	16,236	1,427	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,493,044	75	54,425	0	16,236	592	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	714,650	0	16,236	7,771	19
20	30	Depreciation	Resident Days	1,493,044	75	215,197	0	16,236	2,340	20
21	32	Interest	Resident Days	1,493,044	75	330,981	0	16,236	3,599	21
22	33	Real Estate Taxes	Resident Days	1,493,044	75	33,065	0	16,236	360	22
23	34	Rent-Facility and Grounds	Resident Days	1,493,044	75	0	0	16,236	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,493,044	75	31,635	0	16,236	344	24
25	TOTALS					\$ 8,639,461	\$ 6,088,287		\$ 98,819	25

Facility Name & ID Number Effingham Rehabilitation & Health Care Center

0047159

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	93,320	5	\$	\$	16,236	\$	1
2	2	Food	Resident Days	93,320	5			16,236		2
3	3	Housekeeping	Resident Days	93,320	5			16,236		3
4	4	Laundry	Resident Days	93,320	5			16,236		4
5	5	Utilities	Resident Days	93,320	5			16,236		5
6	6	Maintenance	Resident Days	93,320	5			16,236		6
7	7	Mgmt. Allocation of Benefits	Resident Days	93,320	5			16,236		7
8	10	Nursing and Medical Records	Resident Days	93,320	5			16,236		8
9	15	Mgmt. Allocation of Benefits	Resident Days	93,320	5			16,236		9
10	17	Administrative	Resident Days	93,320	5			16,236		10
11	19	Professional Services	Resident Days	93,320	5	10,378		16,236	1,806	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	93,320	5	10,855		16,236	1,889	12
13	21	Clerical and General Office	Resident Days	93,320	5	26,653		16,236	4,637	13
14	22	Employee Benefits & Payroll	Resident Days	93,320	5	1,442		16,236	251	14
15	23	Inservice Training & Education	Resident Days	93,320	5			16,236		15
16	24	Travel and Seminar	Resident Days	93,320	5			16,236		16
17	25	Other Admin. Staff Transport.	Resident Days	93,320	5			16,236		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	93,320	5			16,236		18
19	27	Mgmt. Allocation of Benefits	Resident Days	93,320	5			16,236		19
20	30	Depreciation	Resident Days	93,320	5	17,132		16,236	2,981	20
21	32	Interest	Resident Days	93,320	5	84,878		16,236	14,767	21
22	33	Real Estate Taxes	Resident Days	93,320	5			16,236		22
23	34	Rent-Facility and Grounds	Resident Days	93,320	5			16,236		23
24	35	Rent-Equipment & Vehicles	Resident Days	93,320	5			16,236		24
25	TOTALS					\$ 151,338	\$		\$ 26,331	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	F&M Bank of Galesburg		X	Mortgage	\$6,884.00	5/6/2008	\$ 793,243	\$ 753,610	5/6/2011	0.0695	\$ 52,740	1							
2												2							
3							Interest Income Offset				(2,744)	3							
4							Home Office Allocation-PHC				3,599	4							
5							Home Office Allocation-PHE				14,767	5							
Working Capital																			
6												6							
7												7							
8												8							
9	TOTAL Facility Related				\$6,884.00		\$ 793,243	\$ 753,610			\$ 68,362	9							
B. Non-Facility Related*																			
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$	14							
15	TOTALS (line 9+line14)						\$ 793,243	\$ 753,610			\$ 68,362	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: 21,644 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>176,400</u>	<u>2005</u>	<u>\$ 50,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	176,400		\$ 50,000	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	62	2005	1998	\$ 718,400	\$	30	\$ 23,947	\$ 23,947	\$ 111,752
5									
6									
7									
8									
Improvement Type**									
9	Fence		2007	19,070		15	1,271	1,271	3,178
10	Landscaping		2007	618		15	41	41	103
11	Landscaping		2007	30,800		15	2,053	2,053	5,133
12	Water Heater		2007	1,020		5	204	204	510
13	3 Awnings		2007	18,050		25	722	722	1,805
14	Remodeling of North & South Nurse's Station		2009	48,047		15	1,602	1,602	1,602
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27	Land Improvements Booked				3,366			(3,366)	
28	Building Booked				23,947			(23,947)	
29	Building Improvement Booked				1,193			(1,193)	
30									
31									
32	2009-Home Office Allocation-Land Improvements			534			34	34	
33	2009-Home Office Allocation-Building Improvements			7,982			191	191	
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)	\$	844,521	\$	28,506	\$	30,065	\$	1,559	\$	124,083	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 231,190	\$ 24,683	\$ 23,185	\$ (1,498)	6-10 yrs.	\$ 102,059	71
72	Current Year Purchases	11,525	457	576	119	10 yrs.	576	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			5,321	5,321			74
75	TOTALS	\$ 242,715	\$ 25,140	\$ 29,082	\$ 3,942		\$ 102,635	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)	\$ 1,137,236	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 53,646	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 59,147	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 5,501	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 226,718	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: \$ 9,515 Description: See Attached Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2006 Ford E250	\$ 578	\$ 6,938	17
18					18
19					19
20					20
21	TOTAL		\$ 578.17	\$ 6,938	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.

Effingham Rehabilitation & Health Care Center
0047159
Period Beginning **1/1/2009**
Period End **12/31/2009**

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$	4,443
Dishwasher		708
Laundry Equipment		1,020
Copier		3,000
Home Office Allocation		344
		<u>9,515</u>

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(1)	276 hrs	\$ 10,530		\$		276	\$ 10,530	1
2	Licensed Speech and Language Development Therapist	10A(1)	1245 hrs	49,421				1,245	49,421	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(1),10A(2)	1070 hrs	55,706			265	1,070	55,971	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				70,533		70,533	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			\$ 115,657		\$	\$ 70,798	2,591	\$ 186,455	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 **Effingham Rehabilitation & Health Care Center**

0047159

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	\$ 347,533	\$ 347,533	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>10,000</u>)	344,311	344,311	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	31,440	31,440	6
7	Other Prepaid Expenses	9,725	9,725	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Prepaid Mgmt. Fees</u>	39,000	39,000	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 772,009	\$ 772,009	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	100,488	50,000	13
14	Buildings, at Historical Cost	718,400	726,382	14
15	Leasehold Improvements, at Historical Cost	67,117	118,139	15
16	Equipment, at Historical Cost	242,714	242,715	16
17	Accumulated Depreciation (book methods)	(223,511)	(226,718)	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)	\$ 905,208	\$ 910,518	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,677,217	\$ 1,682,527	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 280,840	\$ 280,840	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	79,187	79,187	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,245	2,245	31
32	Accrued Real Estate Taxes(Sch.IX-B)	33,000	33,000	32
33	Accrued Interest Payable	3,644	3,644	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Payroll Withholdings</u>	70,445	70,445	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 469,361	\$ 469,361	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	753,610	753,610	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)	\$ 753,610	\$ 753,610	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,222,971	\$ 1,222,971	46
47	TOTAL EQUITY(page 18, line 24)	\$ 454,246	\$ 459,556	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,677,217	\$ 1,682,527	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 494,706	1
2	Restatements (describe):		2
3	2008 Bad Debt Allowance Entered After CR Completion	(10,000)	3
4	Rounding	(3)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 484,703	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(30,457)	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)	\$ (30,457)	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)	\$ 454,246	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Effingham Rehabilitation & Health Care Center # 0047159 Report 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	\$ 1,859,273	1
2	Discounts and Allowances for all Levels	2,499	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,861,772	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	155,718	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 155,718	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	772	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	118,629	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	5,314	20
21	Other Medical Services	1,714	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 126,429	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,744	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,744	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Revenue</u>	80	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 80	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,146,743	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	458,944	31
32	Health Care	1,056,991	32
33	General Administration	333,417	33
B. Capital Expense			
34	Ownership	157,050	34
C. Ancillary Expense			
35	Special Cost Centers	136,853	35
36	Provider Participation Fee	33,945	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,177,200	40
41	Income before Income Taxes (line 30 minus line 40)**	(30,457)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (30,457)	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 Effingham Rehabilitation & Health Care Center

0047159

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	2,109	2,109	\$ 57,831	\$ 27.42	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,689	3,745	83,065	22.18	3
4	Licensed Practical Nurses	8,310	8,501	155,794	18.33	4
5	CNAs & Orderlies	37,551	38,488	403,466	10.48	5
6	CNA Trainees					6
7	Licensed Therapist	2,495	2,591	115,657	44.64	7
8	Rehab/Therapy Aides	2,104	2,110	55,333	26.22	8
9	Activity Director	1,356	1,420	15,670	11.04	9
10	Activity Assistants	384	384	3,470	9.04	10
11	Social Service Workers	2080	2,080	25,481	12.25	11
12	Dietician					12
13	Food Service Supervisor	1,860	1,972	29,416	14.92	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,980	11,431	92,043	8.05	15
16	Dishwashers					16
17	Maintenance Workers	2,080	2,080	29,217	14.05	17
18	Housekeepers	4,855	5,185	43,747	8.44	18
19	Laundry	4,747	4,934	44,206	8.96	19
20	Administrator	2,080	2,080	52,083	25.04	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,080	2,080	23,802	11.44	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	266	266	2,087	7.85	31
32	Other Health Care(specify)					32
33	Other(specify) See Sch. 20A	2,560	2,567	48,495	18.89	33
34	TOTAL (lines 1 - 33)	91,586	94,023	\$ 1,280,863 *	\$ 13.62	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 6,000	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)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 6,600		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

Effingham Rehabilitation & Health Care Center

0047159

Period Beginning 1/1/2009

Period End 12/31/2009

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Marketing	260	260	3,412	13.12
Certified Medical Technician	198	198	1,519	7.67
Care Plan Coordinator	2,091	2,098	43,001	20.50
Restorative	11	11	563	51.18
TOTAL (lines 1 - 35)	2,560	2,567	48,495	

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		
Nathan Scholes	Administrator	0	\$ 52,083	Workers' Compensation Insurance	\$ 37,317	IDPH License Fee	\$ 1,990		
				Unemployment Compensation Insurance	17,808	Advertising: Employee Recruitment	1,939		
				FICA Taxes	93,491	Health Care Worker Background Check			
				Employee Health Insurance	8,937	(Indicate # of checks performed)			
				Employee Meals		Patient Background Checks	135 1,350		
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	471		
				Employee Relations	1,424	Miscellaneous Dues & Subscriptions	931		
						IHCA Dues	1,500		
						Home Office Allocation	2,998		
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 52,083			Less: Public Relations Expense	(805)		
(List each licensed administrator separately.)						Non-allowable advertising	()		
						Yellow page advertising	()		
B. Administrative - Other									
Description			Amount	TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)		
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 84,000	\$ 158,977			\$ 10,374		
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 84,000	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
(Attach a copy of any management service agreement)				Description			Description		
C. Professional Services				Line #			Amount		
Vendor/Payee	Type	Amount	Description			Amount			
E-Health Data Solutions	Computer Services	\$ 2,700	N/A						
Consolidated Communications	Computer Services	578				Out-of-State Travel			
LTC Solutions	Computer Services	1,700							
SimpleLTC, Inc.	Computer Services	81				In-State Travel			
						Seminar Expense			
						Home Office Allocation			
						91			
						Entertainment Expense			
						()			
TOTAL (agree to Schedule V, line 19, column 3)			\$ 5,059	TOTAL			\$ 91		
(If total legal fees exceed \$5,000, attach copy of invoices.)							(agree to Sch. V, line 24, col. 8)		
							TOTAL		

* Attach copy of IMRF notifications

**See instructions.

Effingham Rehabilitation & Health Care Center

0047159

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)		5,059

Home Office Allocation

Heyl, Royster, Voelker & Allen	Legal	25
GoffWilson, P.A.	Legal	36
Jackson Lewis	Legal	285
Peter Gartelos	Legal	28
Misc.	Legal	25
Ginoli & Company	Accountants	2,439
Miscellaneous Vendors	Computer Services	26
Emdeon Business Services	Computer Services	12
Advanced Answers on Demand	Computer Services	1,530
Access 2 Go	Computer Services	147
Ivans	Computer Services	17
Kemper Technology	Computer Services	416
VisionShare	Computer Services	129
MediFax	Computer Services	53
LogmeIn	Computer Services	23
Charter Communications	Computer Services	1
Simple LTC	Computer Services	353
Miscellaneous Vendors	Miscellaneous	242
Total (agree to Schedule V, line 19, column 8)		<u>10,846</u>

Facility Name & ID Number Effingham Rehabilitation & Health Care Center# 0047159Report 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. \$ 9,630 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. \$ 33,945
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. \$ 772
- (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.