

		FOR BHF USE					

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2009
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2009)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH License ID Number: <u>0047464</u></p> <p>Facility Name: <u>Enfield Rehabilitation & Health Care Center</u></p> <p>Address: <u>One North Wilson Street</u> <u>Enfield</u> <u>62835</u> Number City Zip Code</p> <p>County: <u>White</u></p> <p>Telephone Number: <u>(618) 963-2331</u> Fax # <u>(618) 963-2083</u></p> <p>HFS ID Number: <u>20-3224201009</u></p> <p>Date of Initial License for Current Owners: <u>10/01/2005</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Larry Templin</u> Telephone Number: <u>(309) 691-8113</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2009</u> to <u>12/31/2009</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 15%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Mark B. Petersen</u> (Date) _____</td> </tr> <tr> <td></td> <td>(Title) <u>Chief Executive Officer</u></td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> </tr> <tr> <td>(Firm Name & Address) _____</td> </tr> <tr> <td></td> <td>(Telephone) <u>()</u> Fax # <u>()</u></td> </tr> </table> <p>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Mark B. Petersen</u> (Date) _____		(Title) <u>Chief Executive Officer</u>	Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) _____		(Telephone) <u>()</u> Fax # <u>()</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																			
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	(Telephone) <u>()</u> Fax # <u>()</u>																																				

Facility Name & ID Number Enfield Rehabilitation & Health Care Center

0047464 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	49	Intermediate (ICF)	49	17,885	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	49	TOTALS	49	17,885	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	9,250	728	18	9,996	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,250	728	18	9,996	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 55.89%

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 10/1/05

J. Was the facility purchased or leased after January 1, 1978?
YES Date 10/1/05 NO

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number Enfield Rehabilitation & Health Care Center # 0047464 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	97,215	7,464		104,679		104,679	1,748	106,427		1
2	Food Purchase		62,206		62,206		62,206	(3,089)	59,117		2
3	Housekeeping	65,771	8,801		74,572		74,572	16	74,588		3
4	Laundry	6,596	5,773		12,369		12,369		12,369		4
5	Heat and Other Utilities			53,589	53,589		53,589	173	53,762		5
6	Maintenance	14,066	4,144	9,923	28,133		28,133	1,826	29,959		6
7	Other (specify):* <u>Home Off. Ben. All.</u>							316	316		7
8	TOTAL General Services	183,648	88,388	63,512	335,548		335,548	990	336,538		8
	B. Health Care and Programs										
9	Medical Director			4,900	4,900		4,900		4,900		9
10	Nursing and Medical Records	414,280	28,955	600	443,835		443,835	688	444,523		10
10a	Therapy										10a
11	Activities	32,680	214	342	33,236		33,236	(19)	33,217		11
12	Social Services										12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Off. Ben. All.</u>							130	130		15
16	TOTAL Health Care and Programs	446,960	29,169	5,842	481,971		481,971	799	482,770		16
	C. General Administration										
17	Administrative	10,175		85,000	95,175		95,175	(47,181)	47,994		17
18	Directors Fees										18
19	Professional Services			5,192	5,192		5,192	3,133	8,325		19
20	Dues, Fees, Subscriptions & Promotions			4,678	4,678		4,678	1,393	6,071		20
21	Clerical & General Office Expenses		2,338	7,207	9,545		9,545	19,210	28,755		21
22	Employee Benefits & Payroll Taxes			95,747	95,747		95,747		95,747		22
23	Inservice Training & Education							182	182		23
24	Travel and Seminar							56	56		24
25	Other Admin. Staff Transportation			3,703	3,703		3,703	1,054	4,757		25
26	Insurance-Prop.Liab.Malpractice			16,271	16,271		16,271	364	16,635		26
27	Other (specify):* <u>Home Off. Ben. All.</u>							6,889	6,889		27
28	TOTAL General Administration	10,175	2,338	217,798	230,311		230,311	(14,900)	215,411		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	640,783	119,895	287,152	1,047,830		1,047,830	(13,111)	1,034,719		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 Enfield Rehabilitation & Health Care Center #0047464 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			23,980	23,980		23,980	2,346	26,326			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			9,958	9,958		9,958	13,289	23,247			32
33	Real Estate Taxes			6,665	6,665		6,665	221	6,886			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			13,992	13,992		13,992	212	14,204			35
36	Other (specify):*											36
37	TOTAL Ownership			54,595	54,595		54,595	16,068	70,663			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			26,828	26,828		26,828		26,828			42
43	Other (specify):* Non-allowable Cost		599	4,986	5,585		5,585	(5,585)				43
44	TOTAL Special Cost Centers		599	31,814	32,413		32,413	(5,585)	26,828			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	640,783	120,494	373,561	1,134,838		1,134,838	(2,628)	1,132,210			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	(3,128)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,385)	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	296	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(191)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,622)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg. 5A	(924)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (8,954)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	6,326	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 6,326		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (2,628)		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

Enfield Rehabilitation & Health Care Center

ID# 0047464

Report Period Beginning: 1/1/2009

Ending: 12/31/2009

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Resident Flower	\$ (313)	43	1
2	Disallowed Special Events	(74)	43	2
3	Offset of Miscellaneous Revenue-Nursing Supplies	(370)	10	3
4	Offset of Miscellaneous Revenue-Office Supplies	(148)	21	4
5	Offset of Transportation Revenue	(19)	11	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
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41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(924)		49

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 1,748	\$ 1,748	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	39	39	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	16	16	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	173	173	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	847	847	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	316	316	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	1,058	1,058	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%	130	130	10
11	V	17 Administrative	85,000	Petersen Health Care, Inc.	100.00%	37,819	(47,181)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	2,451	2,451	12
13	V							13
14	Total		\$ 85,000			\$ 44,597	\$ * (40,403)	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%	\$ 683	\$	683	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	17,825		17,825	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	182		182	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	56		56	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	878		878	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	364		364	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	4,785		4,785	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	1,441		1,441	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	2,216		2,216	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	221		221	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%	212		212	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		\$			\$ 28,863	\$ *	28,863	39

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

Facility Name & ID Number Enfield Rehabilitation & Health Care Center# 0047464Report Period Beginning: 1/1/2009Ending: 12/31/2009

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1 Dietary	\$	Petersen Health Operations, LLC	100.00%	\$ 0	\$	15	
16	V	2 Food		Petersen Health Operations, LLC	100.00%	0		16	
17	V	3 Housekeeping		Petersen Health Operations, LLC	100.00%	0		17	
18	V	4 Laundry		Petersen Health Operations, LLC	100.00%	0		18	
19	V	5 Utilities		Petersen Health Operations, LLC	100.00%	0		19	
20	V	6 Maintenance		Petersen Health Operations, LLC	100.00%	979	979	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%	682	682	25	
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Operations, LLC	100.00%	710	710	26	
27	V	21 Clerical and General Office		Petersen Health Operations, LLC	100.00%	1,533	1,533	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%	176	176	31	
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Operations, LLC	100.00%	0		32	
33	V	27 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	2,104	2,104	33	
34	V	30 Depreciation		Petersen Health Operations, LLC	100.00%	609	609	34	
35	V	32 Interest		Petersen Health Operations, LLC	100.00%	11,073	11,073	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		\$			\$ 17,866	\$ *	17,866	39

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

Facility Name & ID Number Enfield Rehabilitation & Health Care Center # 0047464 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	157,977	0.39	0.65	Salary	\$ 1,136	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	\$ 1,136		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 Enfield Rehabilitation & Health Care Center

0047464

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	9,996	\$ 1,748	1
2	2	Food	Resident Days	1,493,044	75	5,864	0	9,996	39	2
3	3	Housekeeping	Resident Days	1,493,044	75	2,458	0	9,996	16	3
4	4	Laundry	Resident Days	1,493,044	75	0	0	9,996	0	4
5	5	Utilities	Resident Days	1,493,044	75	25,776	0	9,996	173	5
6	6	Maintenance	Resident Days	1,493,044	75	126,463	107,810	9,996	847	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	47,148	0	9,996	316	7
8	10	Nursing and Medical Records	Resident Days	1,493,044	75	158,020	151,697	9,996	1,058	8
9	10A	Therapy	Resident Days	1,493,044	75	0	0	9,996	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	19,462	0	9,996	130	10
11	17	Administrative	Resident Days	1,493,044	75	3,315,953	3,315,953	9,996	37,819	11
12	19	Professional Services	Resident Days	1,493,044	75	366,089	0	9,996	2,451	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,493,044	75	102,022	0	9,996	683	13
14	21	Clerical and General Office	Resident Days	1,493,044	75	2,662,394	2,253,243	9,996	17,825	14
15	23	Inservice Training & Education	Resident Days	1,493,044	75	27,176	0	9,996	182	15
16	24	Travel and Seminar	Resident Days	1,493,044	75	8,381	0	9,996	56	16
17	25	Other Admin. Staff Transport.	Resident Days	1,493,044	75	131,200	0	9,996	878	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,493,044	75	54,425	0	9,996	364	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	714,650	0	9,996	4,785	19
20	30	Depreciation	Resident Days	1,493,044	75	215,197	0	9,996	1,441	20
21	32	Interest	Resident Days	1,493,044	75	330,981	0	9,996	2,216	21
22	33	Real Estate Taxes	Resident Days	1,493,044	75	33,065	0	9,996	221	22
23	34	Rent-Facility and Grounds	Resident Days	1,493,044	75	0	0	9,996	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,493,044	75	31,635	0	9,996	212	24
25	TOTALS					\$ 8,639,461	\$ 6,088,287		\$ 73,460	25

Facility Name & ID Number Enfield Rehabilitation & Health Care Center# 0047464

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	\$	\$	9,996	\$	1
2	2	Food	Resident Days	399,145	21			9,996		2
3	3	Housekeeping	Resident Days	399,145	21			9,996		3
4	4	Laundry	Resident Days	399,145	21			9,996		4
5	5	Utilities	Resident Days	399,145	21			9,996		5
6	6	Maintenance	Resident Days	399,145	21	39,101		9,996	979	6
7	7	Mgmt. Allocation of Benefits	Resident Days	399,145	21			9,996		7
8	10	Nursing and Medical Records	Resident Days	399,145	21			9,996		8
9	12	Social Services	Resident Days	399,145	21			9,996		9
10	17	Administrative	Resident Days	399,145	21		(1)	9,996		10
11	19	Professional Services	Resident Days	399,145	21	27,247		9,996	682	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	399,145	21	28,366		9,996	710	12
13	21	Clerical and General Office	Resident Days	399,145	21	61,225		9,996	1,533	13
14	22	Employee Benefits & Payroll	Resident Days	399,145	21			9,996		14
15	23	Inservice Training & Education	Resident Days	399,145	21			9,996		15
16	24	Travel and Seminar	Resident Days	399,145	21			9,996		16
17	25	Other Admin. Staff Transport.	Resident Days	399,145	21	7,018		9,996	176	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	399,145	21			9,996		18
19	27	Mgmt. Allocation of Benefits	Resident Days	399,145	21	84,024		9,996	2,104	19
20	30	Depreciation	Resident Days	399,145	21	24,325		9,996	609	20
21	32	Interest	Resident Days	399,145	21	442,158		9,996	11,073	21
22	33	Real Estate Taxes	Resident Days	399,145	21			9,996		22
23	34	Rent-Facility and Grounds	Resident Days	399,145	21			9,996		23
24	35	Rent-Equipment & Vehicles	Resident Days	399,145	21			9,996		24
25	TOTALS					\$ 713,464	\$		\$ 17,866	25

Facility Name & ID Number

Enfield Rehabilitation & Health Care Center

0047464

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Bank of America		X	Mortgage	Varies	1/19/07	\$ 200,000	\$ 193,835	12/31/13	Varies	\$ 9,958	1								
2												2								
3												3								
4							Home Office Allocation-PHC				2,216	4								
5							Home Office Allocation-PHO				11,073	5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related						\$ 200,000	\$ 193,835			\$ 23,247	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 200,000	\$ 193,835			\$ 23,247	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: 10,476 B. General Construction Type: Exterior Brick & Concrete Frame Wood Number of Stories 1

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

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

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

N/A

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>75,359</u>	<u>2005</u>	<u>\$ 15,750</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	75,359		\$ 15,750	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	49	2005	1972	\$ 280,250	\$	25	\$ 11,209	\$ 11,209	\$ 50,442
5									
6									
7									
8									
Improvement Type**									
9	Original Land		2005	10,000		15	667	667	3,001
10	Door Alarm		2007	1,636		15	109	109	273
11	Air Compressor		2007	1,302		15	87	87	217
12	New Roof		2007	29,725		20	1,486	1,486	3,715
13	Awning		2008	2,569		20	128	128	192
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27	Land Improvements Booked				667			(667)	
28	Building Booked				11,253			(11,253)	
29	Building Improvement Booked				1,478			(1,478)	
30									
31									
32	2009-Home Office Allocation-Land Improvements			329			21	21	
33	2009-Home Office Allocation-Building Improvements			4,914			118	118	
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)		\$ 330,725	\$ 13,398		\$ 13,825	\$ 427	\$ 57,840	70

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

Facility Name & ID Number Enfield Rehabilitation & Health Care Center

0047464

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	\$ 79,470	\$ 10,582	\$ 10,451	\$ (131)	7-10 yrs.	\$ 44,571	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Home Office Allocation			2,050	2,050			74
75	TOTALS	\$ 79,470	\$ 10,582	\$ 12,501	\$ 1,919		\$ 44,571	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)	\$ 425,945	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 23,980	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 26,326	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,346	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 102,411	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: \$ 7,266 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	578.16	\$ 6,938	17
18					18
19					19
20					20
21	TOTAL		\$ 578.16	\$ 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.

Enfield Rehabilitation & Health Care Center

00026518

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	\$	3,201
Dishwasher		708
Copier		3,145
Home Office Allocation		212
		<u>7,266</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		hrs							2	
3	Licensed Recreational Therapist	N/A	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		# of prescripts							9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify): _____									12	
13	Other (specify): _____									13	
14	TOTAL			\$		\$	\$		\$	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 Enfield Rehabilitation & Health Care Center# 0047464Report Period Beginning: 1/1/2009Ending: 12/31/2009

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2009

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (701,737)	\$ (701,737)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>N/A</u>)	98,559	98,559	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	24,426	24,426	6
7	Other Prepaid Expenses	5,203	5,203	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Prepaid Mgmt. Fees</u>	15,000	15,000	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (558,549)	\$ (558,549)	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	25,750	15,750	13
14	Buildings, at Historical Cost	280,250	285,164	14
15	Leasehold Improvements, at Historical Cost	35,232	45,561	15
16	Equipment, at Historical Cost	76,131	79,470	16
17	Accumulated Depreciation (book methods)	(97,827)	(102,411)	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)	\$ 319,536	\$ 323,534	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ (239,013)	\$ (235,015)	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 131,029	\$ 131,029	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	14,054	14,054	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,299	2,299	31
32	Accrued Real Estate Taxes(Sch.IX-B)	6,600	6,600	32
33	Accrued Interest Payable	868	868	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	32,216	32,216	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 187,066	\$ 187,066	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	193,835	193,835	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)	\$ 193,835	\$ 193,835	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 380,901	\$ 380,901	46
47	TOTAL EQUITY(page 18, line 24)	\$ (619,914)	\$ (615,916)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (239,013)	\$ (235,015)	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (473,378)	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)	\$ (473,380)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(146,534)	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)	\$ (146,534)	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)	\$ (619,914)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **Enfield Rehabilitation & Health Care Center**# **0047464**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	\$ 983,159	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 983,159	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	3,128	14
15	Telephone, Television and Radio	1,480	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)	\$ 4,608	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Revenue</u>	518	28
28a	<u>Transportation Revenue</u>	19	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 537	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 988,304	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	335,548	31
32	Health Care	481,971	32
33	General Administration	230,311	33
B. Capital Expense			
34	Ownership	54,595	34
C. Ancillary Expense			
35	Special Cost Centers	5,585	35
36	Provider Participation Fee	26,828	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,134,838	40
41	Income before Income Taxes (line 30 minus line 40)**	(146,534)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (146,534)	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 **Enfield Rehabilitation & Health Care Center**

0047464

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	\$ 46,270	\$ 22.25	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,352	4,394	86,175	19.61	3
4	Licensed Practical Nurses	4,843	5,078	73,944	14.56	4
5	CNAs & Orderlies	22,838	23,417	207,891	8.88	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,741	1,789	19,683	11.00	9
10	Activity Assistants	1,179	1,179	9,947	8.44	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,681	1,835	21,279	11.60	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,494	8,850	75,936	8.58	15
16	Dishwashers					16
17	Maintenance Workers	1,539	1,636	14,066	8.60	17
18	Housekeepers	7,361	7,805	65,771	8.43	18
19	Laundry	669	670	6,596	9.84	19
20	Administrator	2,160	2,160	46,858	21.69	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Transportation</u>	380	380	3,050	8.03	33
34	TOTAL (lines 1 - 33)	59,317	61,273	\$ 677,466 *	\$ 11.06	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 4,900	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)	\$ 5,500		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

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	
Raychell Simms	Administrator	0	\$ 21,858	Workers' Compensation Insurance	\$ 24,255	IDPH License Fee	\$ 1,990	
Henry McGill	Administrator	0	25,000	Unemployment Compensation Insurance	15,648	Advertising: Employee Recruitment	389	
				FICA Taxes	48,515	Health Care Worker Background Check		
				Employee Health Insurance	6,360	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks	74 734	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	35	
				Employee Relations	934	Miscellaneous Dues & Subscriptions	30	
				Employee Retirement	35	IHCA Dues	1,500	
						Home Office Allocation	1,393	
TOTAL (agree to Schedule V, line 17, col. 1)						Less: Public Relations Expense	()	
(List each licensed administrator separately.)			\$ 46,858			Non-allowable advertising	()	
						Yellow page advertising	()	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 85,000				Out-of-State Travel	\$
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 85,000				In-State Travel	
(Attach a copy of any management service agreement)								
C. Professional Services				TOTAL			Seminar Expense	
Vendor/Payee	Type	Amount						
E-Data Health	Computer Services	\$ 2,700						
LTC Solutions	Computer Services	1,700						
Verizon Online	Computer Services	603						
SimpleLTC, Inc.	Computer Services	81						
Wilson's Computers	Computer Repair	108						
TOTAL (agree to Schedule V, line 19, column 3)				\$			Home Office Allocation	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 5,192				56	
							Entertainment Expense	
							()	
							TOTAL (agree to Sch. V, line 24, col. 8)	
							\$ 56	

* Attach copy of IMRF notifications

**See instructions.

Enfield Rehabilitation & Health Care Center

0047464

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)		5,192

Home Office Allocation

Heyl, Royster, Voelker & Allen	Legal	(7)
GoffWilson, P.A.	Legal	22
Jackson Lewis	Legal	176
Peter Gartelos	Legal	17
Misc.	Legal	15
Ginoli & Company	Accountants	1,057
Miscellaneous Vendors	Computer Services	16
Emdeon Business Services	Computer Services	7
Advanced Answers on Demand	Computer Services	942
Access 2 Go	Computer Services	91
Ivans	Computer Services	49
Kemper Technology	Computer Services	256
VisionShare	Computer Services	80
MediFax	Computer Services	32
LogmeIn	Computer Services	14
Charter Communications	Computer Services	1
Simple LTC	Computer Services	217
Miscellaneous Vendors	Miscellaneous	148
Total (agree to Schedule V, line 19, column 8)		<u>8,325</u>

Facility Name & ID Number Enfield Rehabilitation & Health Care Center# 0047464Report 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. \$ 6,429 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. \$ 26,828
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. \$ 3,128
- (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.