

Facility Name & ID Number Henderson County Retirement Center

0035246 Report Period Beginning: 01/01/09 Ending: 12/31/09

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 _____

	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	59	Skilled (SNF)	59	21,535	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	59	TOTALS	59	21,535	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF			572	572		8
9	SNF/PED						9
10	ICF	8,816	8,774		17,590		10
11	ICF/DD						11
12	SC						12
13	DD 16 OR LESS						13
14	TOTALS	8,816	8,774	572	18,162		14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.34%

D. How many bed-hold days during this year were paid by the Department? 0 (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)
n/a

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

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 06/28/89

J. Was the facility purchased or leased after January 1, 1978?
YES Date 05/16/89 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 54 and days of care provided 572

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/09 Fiscal Year: 12/31/09

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

Facility Name & ID Number Henderson County Retirement Center # 0035246 Report Period Beginning: 01/01/09 Ending: 12/31/09

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	134,894	15,691	4,775	155,360		155,360		155,360		1
2	Food Purchase		117,713		117,713		117,713	(795)	116,918		2
3	Housekeeping	54,681	8,435		63,116		63,116		63,116		3
4	Laundry	20,005	7,520	17,310	44,835		44,835		44,835		4
5	Heat and Other Utilities			61,178	61,178		61,178		61,178		5
6	Maintenance	47,185	7,825	45,885	100,895		100,895	(24)	100,871		6
7	Other (specify):*										7
8	TOTAL General Services	256,765	157,184	129,148	543,097		543,097	(819)	542,278		8
	B. Health Care and Programs										
9	Medical Director			14,580	14,580		14,580		14,580		9
10	Nursing and Medical Records	750,584	72,488	1,800	824,872		824,872	(86)	824,786		10
10a	Therapy	21,953	232	32,397	54,582	15	54,597		54,597		10a
11	Activities	53,341	6,614	1,623	61,578		61,578		61,578		11
12	Social Services	32,164	181	1,638	33,983	(15)	33,968		33,968		12
13	CNA Training										13
14	Program Transportation			8,240	8,240		8,240		8,240		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	858,042	79,515	60,278	997,835		997,835	(86)	997,749		16
	C. General Administration										
17	Administrative	51,100			51,100		51,100		51,100		17
18	Directors Fees										18
19	Professional Services			44,648	44,648		44,648		44,648		19
20	Dues, Fees, Subscriptions & Promotions			26,212	26,212		26,212	(18,857)	7,355		20
21	Clerical & General Office Expenses	48,947	9,993	11,481	70,421		70,421		70,421		21
22	Employee Benefits & Payroll Taxes			236,828	236,828		236,828		236,828		22
23	Inservice Training & Education			2,169	2,169		2,169		2,169		23
24	Travel and Seminar			2,295	2,295		2,295		2,295		24
25	Other Admin. Staff Transportation			915	915		915		915		25
26	Insurance-Prop.Liab.Malpractice			49,822	49,822		49,822		49,822		26
27	Other (specify):*			274	274		274		274		27
28	TOTAL General Administration	100,047	9,993	374,644	484,684		484,684	(18,857)	465,827		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,214,854	246,692	564,070	2,025,616		2,025,616	(19,762)	2,005,854		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 Henderson County Retirement Center #0035246 Report Period Beginning: 01/01/09 Ending: 12/31/09

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			118,156	118,156		118,156	(12,090)	106,066			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			53,406	53,406	371	53,777	(13,719)	40,058			32
33	Real Estate Taxes			173	173		173	(173)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			3,983	3,983		3,983		3,983			35
36	Other (specify):*											36
37	TOTAL Ownership			175,718	175,718	371	176,089	(25,982)	150,107			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		16,478		16,478		16,478		16,478			39
40	Barber and Beauty Shops		68	7,613	7,681		7,681		7,681			40
41	Coffee and Gift Shops		7,035		7,035		7,035		7,035			41
42	Provider Participation Fee			32,303	32,303		32,303		32,303			42
43	Other (specify):*			7,209	7,209	(371)	6,838	(6,838)				43
44	TOTAL Special Cost Centers		23,581	47,125	70,706	(371)	70,335	(6,838)	63,497			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,214,854	270,273	786,913	2,272,040		2,272,040	(52,582)	2,219,458			45

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

Henderson County Retirement Center

ID# 0035246

Report Period Beginning: 01/01/09

Ending: 12/31/09

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Misc Expenses	\$ (1,391)	43	1
2	Non-Care Related Property Taxes	(173)	33	2
3	Lease Buy-out	(11,996)	30	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(13,560)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Henderson County Retirement Center

0035246

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(795)	0	0	0	0	0	0	0	0	0	0	(795)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(24)	0	0	0	0	0	0	0	0	0	0	(24)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(819)	0	0	0	0	0	0	0	0	0	0	(819)	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	(86)	0	0	0	0	0	0	0	0	0	0	(86)	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	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(86)	0	0	0	0	0	0	0	0	0	0	(86)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(18,857)	0	0	0	0	0	0	0	0	0	0	(18,857)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(18,857)	0	0	0	0	0	0	0	0	0	0	(18,857)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(19,762)	0	0	0	0	0	0	0	0	0	0	(19,762)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Henderson County Retirement Center

0035246

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	(12,090)	0	0	0	0	0	0	0	0	0	0	(12,090)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(13,719)	0	0	0	0	0	0	0	0	0	0	(13,719)	32
33	Real Estate Taxes	(173)	0	0	0	0	0	0	0	0	0	0	(173)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(25,982)	0	0	0	0	0	0	0	0	0	0	(25,982)	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):*	(6,838)	0	0	0	0	0	0	0	0	0	0	(6,838)	43
44	TOTAL Special Cost Centers	(6,838)	0	0	0	0	0	0	0	0	0	0	(6,838)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(52,582)	0	0	0	0	0	0	0	0	0	0	(52,582)	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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

Facility Name & ID Number Henderson County Retirement Center # 0035246 Report Period Beginning: 01/01/09 Ending: 12/31/09

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									\$		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	\$		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 Henderson County Retirement Center

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Report Period Beginning:

01/01/09

Ending: 12/31/09

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 _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number

Henderson County Retirement Center

0035246

Report Period Beginning:

01/01/09

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12/31/09

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		X	2nd Refinance	\$10,949.92	10/23/08	\$ 849,849	\$ 1,727,099	08/01/39	6.2500	\$ 53,406	1								
2											2								
3											3								
4											4								
5											5								
Working Capital																			
6		X	Finance Workmans Comp	\$4,469.40	10/01/08	29,462		09/30/09	2.0000	371	6								
7											7								
8											8								
9	TOTAL Facility Related			\$15,419.32		\$ 879,311	\$ 1,727,099			\$ 53,777	9								
B. Non-Facility Related*																			
10											10								
11											11								
12											12								
13											13								
14	TOTAL Non-Facility Related					\$	\$			\$	14								
15	TOTALS (line 9+line14)					\$ 879,311	\$ 1,727,099			\$ 53,777	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* 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.)

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X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 18,636 B. General Construction Type: Exterior Brick Frame Wood-Steel 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).

Rental Home

Assisted Living Facility

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:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Care Related</u>	<u>217,600</u>	<u>1988</u>	<u>\$ 15,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	217,600		\$ 15,000	3

Facility Name & ID Number Henderson County Retirement Center

0035246

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	60		1989	1988	\$ 1,260,000	\$ 42,031	30	\$ 42,000	\$ (31)	\$ 864,205	4
5	6		2000	2000	530,989	13,301	40	13,275	(26)	124,419	5
6											6
7											7
8											8
	Improvement Type**										
9		PARKING LOT/LANDSCAPING	1989		25,102	764	20	764		25,102	9
10		LANDSCAPING	1990		937	47	20	47		902	10
11		LAND IMPROVEMENT	1995		1,839	92	20	92		1,364	11
12		BRICK SIGN	1996		12,915	620	20	646	26	8,779	12
13		LAND IMPROVEMENT	1992		2,003	101	20	100	(1)	1,718	13
14		LIGHTNING RODS	1998		3,600	240	15	240		2,780	14
15		NEW SOFFITS	1998		26,138	1,752	15	1,743	(9)	20,151	15
16		PHONE SYSTEM	1998		6,738	449	15	449		5,128	16
17		SIDE WALKS	1998		4,500	226	20	225	(1)	2,523	17
18		ALARM SYSTEM	1998		8,266		10			8,266	18
19		LAUNDRY/GARAGE BLDG	1999		50,330	3,374	15	3,355	(19)	34,865	19
20		STORAGE BLDG	1999		8,911	597	15	594	(3)	6,173	20
21		NEW ROOF	1999		16,311	1,094	15	1,087	(7)	11,026	21
22		LANDSCAPING	2000		1,706	85	20	85		782	22
23		FURNICE	2001		2,848	285	10	285		2,540	23
24		NEW EXIT	2001		1,645	110	15	110		965	24
25		LANDSCAPING	2002		954	95	10	95		732	25
26		GARAGE/STORAGE BUILDING	2002		12,800	858	15	853	(5)	6,364	26
27		ROOFING/SHINGLES	2003		17,838	1,192	15	1,189	(3)	7,708	27
28		Walk-in Freezer	2007		20,883	1,044	20	1,044		2,175	28
29		Window Tinting	2007		2,985	150	20	149	(1)	325	29
30		Door Closures	2007		4,345	434	10	434		941	30
31		Window Tinting	2008		1,164	58	20	58		107	31
32		Generator	2009		101,961	2,974	20	2,974		2,974	32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Henderson County Retirement Center

0035246

Report Period Beginning:

01/01/09

Ending:

12/31/09

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)	\$ 2,127,708	\$ 71,973		\$ 71,893	\$ (80)	\$ 1,143,014	70

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

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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	\$ 216,478	\$ 22,068	\$ 22,068	\$	9	\$ 128,755	71
72	Current Year Purchases	9,971	806	806		9	806	72
73	Fully Depreciated Assets	482,288				9	482,288	73
74								74
75	TOTALS	\$ 708,737	\$ 22,874	\$ 22,874	\$		\$ 611,849	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	Care Related	07 Dodge Caravan	2007	\$ 17,725	\$ 3,545	\$ 3,545	\$	5	\$ 9,158	76
77	Care Related	99 Ford Taurus	2007	3,675	749	735	(14)	5	1,803	77
78	Care Related	Bus	2008	35,095	7,019	7,019		5	8,774	78
79										79
80	TOTALS			\$ 56,495	\$ 11,313	\$ 11,299	\$ (14)		\$ 19,735	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)	\$ 2,907,940	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 106,160	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 106,066	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (94)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,774,598	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	Rental Property	\$ 68,955	\$ 2,344	\$ 5,079	86
87	Rental Property	4,597	156	286	87
88	Assisted Living	1,714,048	8,577	8,577	88
89					89
90					90
91	TOTALS	\$ 1,787,600	\$ 11,077	\$ 13,942	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			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: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ _____			3
4	Additions							4
5								5
6								6
7	TOTAL				\$ _____			7

8. List separately any amortization of lease expense included on page 4, line 34. _____

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ 3,983 Description: Oxygen (1,883.03), Copier (2,100.00)

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ _____	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____/2010 \$ _____

13. _____/2011 \$ _____

14. _____/2012 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)					
							Units	Cost								
1	Licensed Occupational Therapist	10a-3	hrs	\$	103	\$ 8,718					103	\$ 8,718				1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		11	744					11	744				2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	10a-3	hrs		272	22,020					272	22,020				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							16,478		16,478				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			\$	385	\$ 31,482	\$	16,478	\$	385	\$ 47,960					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 Henderson County Retirement Center

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XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/09

(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	\$ 72,344	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	231,341		3
4	Supply Inventory (priced at FIFO)	23,435		4
5	Short-Term Investments	477,645		5
6	Prepaid Insurance	19,226		6
7	Other Prepaid Expenses	5,619		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 829,610	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	22,500		13
14	Buildings, at Historical Cost	4,123,384		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	933,882		16
17	Accumulated Depreciation (book methods)	(1,989,320)		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): C-I-P	1,180		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,091,626	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,921,236	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 198,216	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	114,863		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,684		31
32	Accrued Real Estate Taxes(Sch.IX-B)	1,227		32
33	Accrued Interest Payable	13,277		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Group Ins. Withheld</u>	2,196		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 331,463	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,323,221		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)	\$ 2,323,221	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,654,684	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,266,552	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,921,236	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,335,306	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,335,306	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	54,992	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) Rental Division Loss	(1,420)	15
16	Other (describe) Assisted Living Loss	(122,326)	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (68,754)	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)	\$ 1,266,552	24 *

* This must agree with page 17, line 47.

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	\$ 2,252,735	1
2	Discounts and Allowances for all Levels	(8,320)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,244,415	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	5,630	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 5,630	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	7,136	12
13	Barber and Beauty Care	7,467	13
14	Non-Patient Meals	49	14
15	Telephone, Television and Radio	24	15
16	Rental of Facility Space		16
17	Sale of Drugs	1,647	17
18	Sale of Supplies to Non-Patients	86	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	10,876	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 27,285	23
D. Non-Operating Revenue			
24	Contributions	32,301	24
25	Interest and Other Investment Income***	13,719	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 46,020	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See List Attached</u>	3,685	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,685	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,327,035	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	543,097	31
32	Health Care	1,014,316	32
33	General Administration	484,684	33
B. Capital Expense			
34	Ownership	175,718	34
C. Ancillary Expense			
35	Special Cost Centers	21,925	35
36	Provider Participation Fee	32,303	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,272,043	40
41	Income before Income Taxes (line 30 minus line 40)**	54,992	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 54,992	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** 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.

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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	1,717	2,088	\$ 48,967	\$ 23.45	1
2	Assistant Director of Nursing	1,778	1,936	34,735	17.94	2
3	Registered Nurses	2,565	2,885	58,561	20.30	3
4	Licensed Practical Nurses	12,574	14,005	235,884	16.84	4
5	CNAs & Orderlies	34,032	35,848	327,381	9.13	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,889	2,142	21,953	10.25	8
9	Activity Director	1,824	2,088	24,323	11.65	9
10	Activity Assistants	3,178	3,409	29,018	8.51	10
11	Social Service Workers	2,654	3,109	32,164	10.35	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,776	2,088	21,736	10.41	14
15	Cook Helpers/Assistants	4,757	5,099	69,357	13.60	15
16	Dishwashers	7,393	8,156	43,801	5.37	16
17	Maintenance Workers	3,152	3,385	47,185	13.94	17
18	Housekeepers	6,198	6,667	54,681	8.20	18
19	Laundry	1,737	1,942	20,005	10.30	19
20	Administrator	1,880	2,088	51,100	24.47	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,553	3,916	48,947	12.50	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 Plan	2,022	2,180	45,056	20.67	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	94,679	103,031	\$ 1,214,854 *	\$ 11.79	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	\$ 4,775	1-3	35
36	Medical Director	Contract	9-3	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Contract	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	Contract	11-3	44
45	Social Service Consultant	Contract	12-3	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 24,401		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			51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)	\$		53

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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. LSN \$1,949
- (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? _____
- (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? _____
- (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
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 16,955 Line 10-2
- (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? No
If YES, give effective date of lease. _____
- (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.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 32,303
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? Yes 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. \$ 49
- (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. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 90
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
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? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Bennett & Middendorf
- (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.

Henderson County Retirement Center, Inc.

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01/01/09 to 12/31/09

Schedule V. Line 6, Column 3

REPAIRS & MAINT DIETARY	\$389.20
REPAIRS & MAINT BUILDING	\$19,091.76
REPAIRS & MAINT EQUIP	\$546.20
REPAIRS & MAINT GROUNDS	\$1,178.50
REPAIRS & MAINT LAUNDRY	\$32.52
REPAIRS & MAINT HSK	\$0.00
REPAIRS & MAINT CABLE	\$1,179.40
REPAIRS & MAINT ALARM	\$0.00
REPAIRS & MAINT GEN/ADM	\$3,653.14
OUTSIDE SERVICES	\$5,048.75
REFUSE	\$14,765.64
TOTAL	<u><u>\$45,885.11</u></u>

Schedule V. Line 21, Column 3

TELEPHONE EXPENSE	\$6,161.62
Board Minutes	\$275.00
Software Support	\$3,892.50
IVANS Medicare Billings	\$1,151.58
TOTAL	<u><u>\$11,480.70</u></u>

Schedule V. Line 14 & 25, Column 2 (90% to line 14)

Auto Exp. & Service	\$1,670.70
Auto Gas & Oil	\$4,142.09
Business Mileage Expense	\$192.47
Bus Driver	\$3,150.00
	<u>\$9,155.26</u>

Schedule V. Line 43, Column 3

Misc. Exp.	\$1,762.30
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Bad Debt	\$5,197.00
Charitable Contributions	\$250.00
	<u>\$7,209.30</u>

Schedule XX. Question 12

All salaries are allocated on the basis of actual time worked in each department.

Schedule XVII, Line 28a, Column 1

Nursing Supplies	\$468.41
Transportation Income	\$1,464.52
Admission Income	\$180.00
Personal Purchase income	\$37.58
Rebates	\$746.00
Dues	\$725.00
Misc. Income	\$63.94
Rounding	
	<u><u>\$3,685.45</u></u>

Schedule XIX, Section F.

LTCNA Dues	\$50.00
G. Neil Dues	\$54.99
AANAC Renewal Fee	\$110.00
Subscriptions	\$809.24
AAHAC Membership	\$627.55
Henderson County Econ. Dev. Corp	\$200.00
Stronghurst Booster Club Membership	\$20.00
Cobra Fee	\$396.00
Secretary of State	\$134.00
IL Charity Fund	\$15.00
Sec of State (Annual Fee)	\$10.00
IL Dept Of Financial & Professional Reg. (Adm Lices	\$100.00
IL Department of Public Health (Dietary Fee)	\$35.00
	<u><u>\$2,561.78</u></u>

Henderson County Retirement Center, Inc.

#0035246

01/01/09 to 12/31/09

Board Members

Diana Doran, Pres 2008
Box 417
Carman, IL 61425

Judy Roessler
RR1, Box 11
Media, IL 61460

Sally Fisher 2006
RR 1
Lomax, IL 61454

Tom Edmonds, 2006
RR 1, Box 129
Lomax, IL 61454

John Allaman, Treas. 2007
RR 1
Kirkwood, IL 61447

Tom Pullen
Box 199
Gladstone, IL 61437

Nancy Stevenson, Sec. 2008
RR 1
Gladstone, IL 61437

David Gerst
RR 1, Box 111
Lomax, IL 61454

Ralph Tatge, 2007 (Vice Pres.)
Box 535
Stronghurst, IL 61480

Honorary Board Members

Laura Kent Donahue
Zach Stamp

Henderson County Retirement Center, Inc.

#0035246

01/01/09 to 12/31/09

Reclassifications

1 Reclassify \$371.00 from Misc exp and into Other Interest for Professional Liabil

2 Reclassify \$15.00 from Social Services exp and into Therapy for Miscoded Therapy

3 Reclassify \$

4 Reclassify \$

5 Reclassify \$

6 Reclassify \$

Henderson County Retirement Center, Inc.

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01/01/09 to 12/31/09

Vendor Name	Name of In-Service	Amount
Life Service Network Foundation	Psychosocial Adaptation: Are You Missing Out on Medicaid \$	\$ 99.00
Polaris Group	MDS 3.0 - Now and Future LIVE	\$ 119.00
Polaris Group	Cut Letters and Generic Notices	\$ 119.00
KRM Information Serv.	Enduring Truths about the Practices of Leadership	\$ 249.00
LSN Conference	Quality of Care and Pain - Changes to Interpretive Guidance	\$ 99.00
Fisher's Jack 'n' Jill	Training by Mike Connell - Leadership Training	\$ 41.51
Lari Jo Smith	CPR Training	\$ 180.00
HC Pro	The C.N.A. Training Solution Video Orientation	\$ 149.00
LSN Foundation	Fingerprint Background Check Rules - Everything You Need To Know	\$ 99.00
Polaris Group	Navigating the SNF Prospective Payment System for FY2010 & 2011	\$ 179.00
ElderCare Communications	Safety-DVD	\$ 171.95
Carole Dillon - Teepa Snow	It's All In Your Approach - by Teepa Snow	\$ 35.00
Paradise	Don't Fire Them, Fire Them Up!	\$ 191.40
ElderCare Communications	Infection Control DVD	\$ 101.98
ElderCare Communications	Skin Care DVD	\$ 89.98
ElderCare Communications	Resident's Rights-Staff DVD	\$ 79.98
Lari Jo Smith	CPR Training	\$ 165.00
	Total for Year	\$ 2,168.80

