



Facility Name & ID Number Lebanon Care Center

# 0049064 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	90	Skilled (SNF)	90	32,850	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	90	TOTALS	90	32,850	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	15,981	3,397	2,465	21,843	8	
9	SNF/PED					9	
10	ICF					10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	15,981	3,397	2,465	21,843	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.49%

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 7/31/2007

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 7/31/2007 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 90 and days of care provided 1,428

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

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

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

Facility Name & ID Number Lebanon Care Center # 0049064 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
	<b>A. General Services</b>										
1	Dietary	119,737	9,804		129,541		129,541	3,820	133,361		1
2	Food Purchase		107,478		107,478		107,478	(1,676)	105,802		2
3	Housekeeping	68,317	16,789		85,106		85,106	36	85,142		3
4	Laundry	30,927	7,719		38,646		38,646		38,646		4
5	Heat and Other Utilities			78,273	78,273		78,273	377	78,650		5
6	Maintenance	31,852	8,052	14,441	54,345		54,345	1,850	56,195		6
7	Other (specify):* <u>Home Off. Ben. All.</u>							690	690		7
8	<b>TOTAL General Services</b>	250,833	149,842	92,714	493,389		493,389	5,097	498,486		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			4,800	4,800		4,800		4,800		9
10	Nursing and Medical Records	800,977	48,831	1,515	851,323		851,323	574	851,897		10
10a	Therapy			311,547	311,547		311,547		311,547		10a
11	Activities	34,916	444	(96)	35,264		35,264		35,264		11
12	Social Services	1,040			1,040		1,040		1,040		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Off. Ben. All.</u>							285	285		15
16	<b>TOTAL Health Care and Programs</b>	836,933	49,275	317,766	1,203,974		1,203,974	859	1,204,833		16
	<b>C. General Administration</b>										
17	Administrative	15,625		110,600	126,225		126,225	(61,242)	64,983		17
18	Directors Fees										18
19	Professional Services			9,433	9,433		9,433	7,357	16,790		19
20	Dues, Fees, Subscriptions & Promotions			9,819	9,819		9,819	1,958	11,777		20
21	Clerical & General Office Expenses	30,988	3,479	9,048	43,515		43,515	43,609	87,124		21
22	Employee Benefits & Payroll Taxes			171,966	171,966		171,966	6,979	178,945		22
23	Inservice Training & Education							398	398		23
24	Travel and Seminar							123	123		24
25	Other Admin. Staff Transportation			789	789		789	1,919	2,708		25
26	Insurance-Prop.Liab.Malpractice			29,637	29,637		29,637	796	30,433		26
27	Other (specify):* <u>Home Off. Ben. All.</u>							10,455	10,455		27
28	<b>TOTAL General Administration</b>	46,613	3,479	341,292	391,384		391,384	12,352	403,736		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,134,379	202,596	751,772	2,088,747		2,088,747	18,308	2,107,055		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 Lebanon Care Center

#0049064

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			101,047	101,047		101,047	(8,930)	92,117			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			121,460	121,460		121,460	18,306	139,766			32
33	Real Estate Taxes			55,797	55,797		55,797	484	56,281			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			9,368	9,368		9,368	463	9,831			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			287,672	287,672		287,672	10,323	297,995			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		48,970		48,970		48,970		48,970			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			49,275	49,275		49,275		49,275			42
43	Other (specify):* <b>Non-allowable Cost</b>		70	98,082	98,152		98,152	(98,152)				43
44	<b>TOTAL Special Cost Centers</b>		49,040	147,357	196,397		196,397	(98,152)	98,245			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,134,379	251,636	1,186,801	2,572,816		2,572,816	(69,521)	2,503,295			45

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



Lebanon Care Center

ID# 0049064

Report Period Beginning: 1/1/2009

Ending: 12/31/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (2,730)	43	1
2	X-Rays-Part A	(856)	43	2
3	Offset Miscellaneous Nursing Supplies Revenue	(1,738)	10	3
4	Offset Miscellaneous Food Revenue	(1,762)	2	4
5	Offset Miscellaneous Office Supplies Revenue	(78)	21	5
6	Resident Flowers	(60)	43	6
7	Special Events	(264)	43	7
8	Pet Expense	(1,530)	43	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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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	<b>Total</b>	(9,018)		49

**VII. RELATED PARTIES**

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 3,820	\$ 3,820	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	86	86	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	36	36	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	377	377	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	1,850	1,850	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	690	690	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	2,312	2,312	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%	285	285	10
11	V	17 Administrative	110,600	Petersen Health Care, Inc.	100.00%	49,358	(61,242)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	5,356	5,356	12
13	V							13
14	Total		\$ 110,600			\$ 64,170	\$ * (46,430)	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%	\$ 1,493	\$	1,493	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	38,950		38,950	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	398		398	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	123		123	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	1,919		1,919	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	796		796	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	10,455		10,455	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	3,148		3,148	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	4,842		4,842	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	484		484	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%	463		463	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		\$			\$ 63,071	\$ *	63,071	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1 Dietary	\$	Petersen Companies, LLC	100.00%	\$ 0	\$	15	
16	V	2 Food		Petersen Companies, LLC	100.00%	0		16	
17	V	3 Housekeeping		Petersen Companies, LLC	100.00%	0		17	
18	V	4 Laundry		Petersen Companies, LLC	100.00%	0		18	
19	V	5 Utilities		Petersen Companies, LLC	100.00%	0		19	
20	V	6 Maintenance		Petersen Companies, LLC	100.00%	0		20	
21	V	7 Mgmt. Allocation of Benefits		Petersen Companies, LLC	100.00%	0		21	
22	V	10 Nursing and Medical Records		Petersen Companies, LLC	100.00%	0		22	
23	V	10A Therapy		Petersen Companies, LLC	100.00%	0		23	
24	V	15 Mgmt. Allocation of Benefits		Petersen Companies, LLC	100.00%	0		24	
25	V	17 Administrative		Petersen Companies, LLC	100.00%	0		25	
26	V	19 Professional Services		Petersen Companies, LLC	100.00%	2,001	2,001	26	
27	V	20 Dues, Fees, Subs & Promotions		Petersen Companies, LLC	100.00%	465	465	27	
28	V	21 Clerical and General Office		Petersen Companies, LLC	100.00%	4,737	4,737	28	
29	V	22 Employee Benefits & Payroll		Petersen Companies, LLC	100.00%	6,979	6,979	29	
30	V	24 Travel and Seminar		Petersen Companies, LLC	100.00%	0		30	
31	V	25 Other Admin. Staff Transport.		Petersen Companies, LLC	100.00%	0		31	
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Companies, LLC	100.00%	0		32	
33	V	27 Mgmt. Allocation of Benefits		Petersen Companies, LLC	100.00%	0		33	
34	V	30 Depreciation		Petersen Companies, LLC	100.00%	517	517	34	
35	V	32 Interest		Petersen Companies, LLC	100.00%	9,460	9,460	35	
36	V	33 Real Estate Taxes		Petersen Companies, LLC	100.00%	0		36	
37	V	34 Rent-Facility and Grounds		Petersen Companies, LLC	100.00%	0		37	
38	V	35 Rent-Equipment & Vehicles		Petersen Companies, LLC	100.00%	0		38	
39	Total		\$			\$ 24,159	\$ *	24,159	39

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

Facility Name & ID Number Lebanon Care Center# 0049064Report 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 Network, LLC	100.00%	\$	\$	15
16	V	2 Food		Petersen Health Network, LLC	100.00%			16
17	V	3 Housekeeping		Petersen Health Network, LLC	100.00%			17
18	V	4 Laundry		Petersen Health Network, LLC	100.00%			18
19	V	5 Utilities		Petersen Health Network, LLC	100.00%			19
20	V	6 Maintenance		Petersen Health Network, LLC	100.00%			20
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Network, LLC	100.00%			21
22	V	10 Nursing and Medical Records		Petersen Health Network, LLC	100.00%			22
23	V	10A Therapy		Petersen Health Network, LLC	100.00%			23
24	V	15 Mgmt. Allocation of Benefits		Petersen Health Network, LLC	100.00%			24
25	V	17 Administrative		Petersen Health Network, LLC	100.00%			25
26	V	19 Professional Services		Petersen Health Network, LLC	100.00%			26
27	V	20 Dues, Fees, Subs & Promotions		Petersen Health Network, LLC	100.00%			27
28	V	21 Clerical and General Office		Petersen Health Network, LLC	100.00%			28
29	V	23 Inservice Training & Education		Petersen Health Network, LLC	100.00%			29
30	V	24 Travel and Seminar		Petersen Health Network, LLC	100.00%			30
31	V	25 Other Admin. Staff Transport.		Petersen Health Network, LLC	100.00%			31
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Network, LLC	100.00%			32
33	V	27 Mgmt. Allocation of Benefits		Petersen Health Network, LLC	100.00%			33
34	V	30 Depreciation		Petersen Health Network, LLC	100.00%			34
35	V	32 Interest		Petersen Health Network, LLC	100.00%	5,814	5,814	35
36	V	33 Real Estate Taxes		Petersen Health Network, LLC	100.00%			36
37	V	34 Rent-Facility and Grounds		Petersen Health Network, LLC	100.00%			37
38	V	35 Rent-Equipment & Vehicles		Petersen Health Network, LLC	100.00%			38
39	Total		\$			\$ 5,814	\$ * 5,814	39

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

Facility Name &amp; ID Number

Lebanon Care Center

# 0049064

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	156,630	0.85	1.42	Salary	\$ 2,483	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	\$ 2,483		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 Lebanon Care Center

# 0049064

Report Period Beginning:

1/1/2009

Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,493,044	75	\$ 261,102	\$ 259,584	21,843	\$ 3,820	1
2	2	Food	Resident Days	1,493,044	75	5,864	0	21,843	86	2
3	3	Housekeeping	Resident Days	1,493,044	75	2,458	0	21,843	36	3
4	4	Laundry	Resident Days	1,493,044	75	0	0	21,843	0	4
5	5	Utilities	Resident Days	1,493,044	75	25,776	0	21,843	377	5
6	6	Maintenance	Resident Days	1,493,044	75	126,463	107,810	21,843	1,850	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	47,148	0	21,843	690	7
8	10	Nursing and Medical Records	Resident Days	1,493,044	75	158,020	151,697	21,843	2,312	8
9	10A	Therapy	Resident Days	1,493,044	75	0	0	21,843	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	19,462	0	21,843	285	10
11	17	Administrative	Resident Days	1,493,044	75	3,315,953	3,315,953	21,843	49,358	11
12	19	Professional Services	Resident Days	1,493,044	75	366,089	0	21,843	5,356	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,493,044	75	102,022	0	21,843	1,493	13
14	21	Clerical and General Office	Resident Days	1,493,044	75	2,662,394	2,253,243	21,843	38,950	14
15	23	Inservice Training & Education	Resident Days	1,493,044	75	27,176	0	21,843	398	15
16	24	Travel and Seminar	Resident Days	1,493,044	75	8,381	0	21,843	123	16
17	25	Other Admin. Staff Transport.	Resident Days	1,493,044	75	131,200	0	21,843	1,919	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,493,044	75	54,425	0	21,843	796	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	714,650	0	21,843	10,455	19
20	30	Depreciation	Resident Days	1,493,044	75	215,197	0	21,843	3,148	20
21	32	Interest	Resident Days	1,493,044	75	330,981	0	21,843	4,842	21
22	33	Real Estate Taxes	Resident Days	1,493,044	75	33,065	0	21,843	484	22
23	34	Rent-Facility and Grounds	Resident Days	1,493,044	75	0	0	21,843	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,493,044	75	31,635	0	21,843	463	24
25	TOTALS					\$ 8,639,461	\$ 6,088,287		\$ 127,241	25

Facility Name & ID Number Lebanon Care Center

# 0049064

Report Period Beginning:

1/1/2009

Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Petersen Companies, 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	198,749	13	\$	\$	18,499	\$	1
2	2	Food	Resident Days	198,749	13			18,499		2
3	3	Housekeeping	Resident Days	198,749	13			18,499		3
4	4	Laundry	Resident Days	198,749	13			18,499		4
5	5	Utilities	Resident Days	198,749	13			18,499		5
6	6	Maintenance	Resident Days	198,749	13			18,499		6
7	7	Mgmt. Allocation of Benefits	Resident Days	198,749	13			18,499		7
8	10	Nursing and Medical Records	Resident Days	198,749	13			18,499		8
9	10A	Therapy	Resident Days	198,749	13			18,499		9
10	15	Mgmt. Allocation of Benefits	Resident Days	198,749	13			18,499		10
11	17	Administrative	Resident Days	198,749	13			18,499		11
12	19	Professional Services	Resident Days	198,749	13	21,502		18,499	2,001	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	198,749	13	4,999		18,499	465	13
14	21	Clerical and General Office	Resident Days	198,749	13	50,893		18,499	4,737	14
15	22	Employee Benefits & Payroll	Resident Days	198,749	13	74,975		18,499	6,979	15
16	24	Travel and Seminar	Resident Days	198,749	13			18,499		16
17	25	Other Admin. Staff Transport.	Resident Days	198,749	13			18,499		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	198,749	13			18,499		18
19	27	Mgmt. Allocation of Benefits	Resident Days	198,749	13			18,499		19
20	30	Depreciation	Resident Days	198,749	13	5,550		18,499	517	20
21	32	Interest	Resident Days	198,749	13	101,632		18,499	9,460	21
22	33	Real Estate Taxes	Resident Days	198,749	13			18,499		22
23	34	Rent-Facility and Grounds	Resident Days	198,749	13			18,499		23
24	35	Rent-Equipment & Vehicles	Resident Days	198,749	13			18,499		24
25	TOTALS					\$ 259,551	\$		\$ 24,159	25

Facility Name & ID Number Lebanon Care Center

# 0049064

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

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	32,882	12	\$	\$	3,344	\$	1
2	2	Food	Resident Days	32,882	12			3,344		2
3	3	Housekeeping	Resident Days	32,882	12			3,344		3
4	4	Laundry	Resident Days	32,882	12			3,344		4
5	5	Utilities	Resident Days	32,882	12			3,344		5
6	6	Maintenance	Resident Days	32,882	12			3,344		6
7	7	Mgmt. Allocation of Benefits	Resident Days	32,882	12			3,344		7
8	10	Nursing and Medical Records	Resident Days	32,882	12			3,344		8
9	10A	Therapy	Resident Days	32,882	12			3,344		9
10	15	Mgmt. Allocation of Benefits	Resident Days	32,882	12			3,344		10
11	17	Administrative	Resident Days	32,882	12			3,344		11
12	19	Professional Services	Resident Days	32,882	12			3,344		12
13	20	Dues, Fees, Subs & Promotions	Resident Days	32,882	12			3,344		13
14	21	Clerical and General Office	Resident Days	32,882	12			3,344		14
15	23	Inservice Training & Education	Resident Days	32,882	12			3,344		15
16	24	Travel and Seminar	Resident Days	32,882	12			3,344		16
17	25	Other Admin. Staff Transport.	Resident Days	32,882	12			3,344		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	32,882	12			3,344		18
19	27	Mgmt. Allocation of Benefits	Resident Days	32,882	12			3,344		19
20	30	Depreciation	Resident Days	32,882	12			3,344		20
21	32	Interest	Resident Days	32,882	12	57,172		3,344	5,814	21
22	33	Real Estate Taxes	Resident Days	32,882	12			3,344		22
23	34	Rent-Facility and Grounds	Resident Days	32,882	12			3,344		23
24	35	Rent-Equipment & Vehicles	Resident Days	32,882	12			3,344		24
25	TOTALS					\$ 57,172	\$		\$ 5,814	25

Facility Name & ID Number

Lebanon Care Center

# 0049064

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										
										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			
<b>A. Directly Facility Related</b>																			
<b>Long-Term</b>																			
1	Soy Bank & Trust		X	Facility	\$12,966.00	8/1/07	\$ 1,542,000	\$	Paid	0.0795	\$ 98,979	1							
2	The Private Bank		X	Mortgage	Varies	10/31/09	1,917,567	1,912,561	11/1/14	Varies	13,761	2							
3												3							
4												4							
5							Interest Income Offset				(1,810)	5							
<b>Working Capital</b>																			
6												6							
7												7							
8												8							
9	<b>TOTAL Facility Related</b>				\$12,966.00		\$ 3,459,567	\$ 1,912,561			\$ 110,930	9							
<b>B. Non-Facility Related*</b>																			
10							Amortization of Loan Costs				8,720	10							
11							Home Office Allocation-PHC				4,842	11							
12							Home Office Allocation-PC				9,460	12							
13							Home Office Allocation-PHN				5,814	13							
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ 28,836	14							
15	<b>TOTALS (line 9+line14)</b>						\$ 3,459,567	\$ 1,912,561			\$ 139,766	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.)





Facility Name & ID Number Lebanon Care Center

# 0049064 Report Period Beginning:

1/1/2009 Ending:

12/31/2009

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 31,919 B. General Construction Type: Exterior Brick Frame Concrete & 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).

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:**

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Facility</u>	<u>17,240</u>	<u>2007</u>	<u>\$ 100,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>17,240</b>		<b>\$ 100,000</b>	<b>3</b>

Facility Name & ID Number Lebanon Care Center

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	90		2007	1986	\$ 1,425,000	\$	25	\$ 57,000	\$ 57,000	\$ 142,500	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		Original Land Improvements	2007		15,000		15	1,000	1,000	2,500	9
10		Lobby Carpet	2007		2,050		7	293	293	733	10
11		Facility Sign	2007		640		7	91	91	228	11
12		Wood Blinds	2007		1,158		7	165	165	413	12
13		Cable Equipment Installation	2009		7,264		7	519	519	519	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		Land Improvements Booked				1,000			(1,000)		27
28		Building Booked				57,000			(57,000)		28
29		Building Improvement Booked				1,069			(1,069)		29
30											30
31											31
32		2009-Home Office Allocation-Land Improvements			718			45	45		32
33		2009-Home Office Allocation-Building Improvements			10,738			258	258		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

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)	\$ 1,462,568	\$ 59,069		\$ 59,371	\$ 302	\$ 146,893	70

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

Facility Name & ID Number Lebanon Care Center

# 0049064

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	\$ 293,842	\$ 41,978	\$ 29,384	\$ (12,594)	10 yrs.	\$ 72,399	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Home Office Allocation			3,362	3,362			74
75	TOTALS	\$ 293,842	\$ 41,978	\$ 32,746	\$ (9,232)		\$ 72,399	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,856,410	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 101,047	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 92,117	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (8,930)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 219,292	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: \$ 5,523 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	2009 Ford E150	\$ 538.52	\$ 4,308	17
18					18
19					19
20					20
21	TOTAL		\$ 538.52	\$ 4,308	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.

**Lebanon Care Center  
0049064**

**Period Beginning 1/1/2009  
Period End 12/31/2009**

**Schedule 14A**

**XII. Rental Costs**

**B. Equipment**

**16. Description of rental amount for movable equipment**

Medical Equipment	\$	1,413
Dishwasher		708
Copier		2,939
Home Office Allocation		463
		<u>5,523</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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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)	
<b>TOTAL TRAINED</b>	

- (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	\$	8,712	\$ 130,683				8,712	\$ 130,683					1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,914	28,709				1,914	28,709					2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		10,144	152,155				10,144	152,155					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							48,970					48,970	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	<b>TOTAL</b>			\$	20,770	\$ 311,547				\$ 48,970			20,770	\$	360,517	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 Lebanon Care Center# 0049064Report 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	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 598,300	\$ 598,300	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>N/A</u> )	490,323	490,323	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	44,865	44,865	6
7	Other Prepaid Expenses	9,431	9,431	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,142,919	\$ 1,142,919	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	115,000	100,000	13
14	Buildings, at Historical Cost	1,425,000	1,435,738	14
15	Leasehold Improvements, at Historical Cost	11,112	26,830	15
16	Equipment, at Historical Cost	293,842	293,842	16
17	Accumulated Depreciation (book methods)	(243,801)	(219,292)	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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,601,153	\$ 1,637,118	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 2,744,072	\$ 2,780,037	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 352,258	\$ 352,258	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	60,083	60,083	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,341	2,341	31
32	Accrued Real Estate Taxes(Sch.IX-B)	56,500	56,500	32
33	Accrued Interest Payable	7,000	7,000	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Payroll Withholdings</u>	47,499	47,499	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 525,681	\$ 525,681	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,912,561	1,912,561	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 1,912,561	\$ 1,912,561	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,438,242	\$ 2,438,242	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 305,830	\$ 341,795	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 2,744,072	\$ 2,780,037	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>234,057</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Prior Period adjustments</b>	<b>(132,496)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>101,561</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>206,192</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe) <b>Rounding</b>	<b>7</b>	<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>206,199</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>	<b>Transfer of Net Assets</b>	<b>(1,930)</b>	<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$ <b>(1,930)</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>305,830</b>	<b>24</b> *

\* This must agree with page 17, line 47.

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**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,259,263	1
2	Discounts and Allowances for all Levels	(27,809)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 2,231,454</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	444,955	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 444,955</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
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	1,762	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	90,446	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	4,475	20
21	Other Medical Services	2,290	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 98,973</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	1,810	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 1,810</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Miscellaneous Revenue</u>	1,816	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 1,816</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 2,779,008</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	493,389	31
32	Health Care	1,203,974	32
33	General Administration	391,384	33
<b>B. Capital Expense</b>			
34	Ownership	287,672	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	147,122	35
36	Provider Participation Fee	49,275	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 2,572,816</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>206,192</b>	<b>41</b>
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 206,192</b>	<b>43</b>

\* 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 **Lebanon Care Center**

# **0049064**

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	1,956	2,076	59,893	\$ 28.85	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,693	3,807	86,523	22.73	3
4	Licensed Practical Nurses	13,559	14,130	266,127	18.83	4
5	CNAs & Orderlies	37,732	38,466	356,446	9.27	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,116	3,187	34,916	10.96	9
10	Activity Assistants					10
11	Social Service Workers	87	87	1,040	11.95	11
12	Dietician					12
13	Food Service Supervisor	2,326	2,326	24,482	10.53	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,224	10,655	95,255	8.94	15
16	Dishwashers					16
17	Maintenance Workers	2,080	2,080	31,852	15.31	17
18	Housekeepers	7,624	7,932	68,317	8.61	18
19	Laundry	3,784	3,871	30,927	7.99	19
20	Administrator	2,080	2,080	62,500	30.05	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,081	2,081	30,988	14.89	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 Restorative	85	85	849	9.99	32
33	Other(specify) <u>Care Plan Coord.</u>	1,526	1,526	31,139	20.41	33
34	TOTAL (lines 1 - 33)	91,953	94,389	\$ 1,181,254 *	\$ 12.51	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	4,800	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	950	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)		\$ 5,750		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

Facility Name & ID Number Lebanon Care Center

# 0049064

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**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		
Terri Rumler	Administrator	0	\$ 62,500	Workers' Compensation Insurance	\$ 42,931	IDPH License Fee	\$ 1,990		
				Unemployment Compensation Insurance	22,681	Advertising: Employee Recruitment	6,029		
				FICA Taxes	85,593	Health Care Worker Background Check			
				Employee Health Insurance	19,295	(Indicate # of checks performed )			
				Employee Meals		Patient Background Checks	142 1,420		
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	380		
				Employee Relations	8,376	Miscellaneous Dues & Subscriptions	0		
				Employee Retirement	69	IHCA Dues	0		
						Home Office Allocation	1,958		
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 62,500			Less: Public Relations Expense	( )		
(List each licensed administrator separately.)						Non-allowable advertising	( )		
						Yellow page advertising	( )		
<b>B. Administrative - Other</b>				TOTAL (agree to Schedule V, line 22, col.8)			\$ 178,945		
Description			Amount	TOTAL (agree to Sch. V, line 20, col. 8)					
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 110,600	\$ 11,777					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 110,600						
(Attach a copy of any management service agreement)									
<b>C. Professional Services</b>				<b>E. Schedule of Non-Cash Compensation Paid to Owners or Employees</b>			<b>G. Schedule of Travel and Seminar**</b>		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
E-Health Data Solutions	Computer Services		\$ 2,800				Out-of-State Travel	\$	
LTC Solutions	Computer Services		1,700						
AT&T	Computer Services		196						
SimpleLTC, Inc.	Computer Services		81	N/A			In-State Travel		
Clifton Gunderson LLP	Accounting Services		3,000						
Heyl, Royster, Voelker & Allen	Legal Services		1,426						
Abacus Professional Services	Accounting Services		230				Seminar Expense		
							Home Office Allocation	123	
							Entertainment Expense	( )	
TOTAL (agree to Schedule V, line 19, column 3)			\$ 9,433	TOTAL			\$	TOTAL (agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)								\$ 123	

\* Attach copy of IMRF notifications

\*\*See instructions.

**Lebanon Care Center**

**0049064**

**Period Beginning 1/1/2009**

**Period End 12/31/2009**

**Schedule 21A**

**XIX. SUPPORT SCHEDULE**

**C. Professional Services**

<b>Vendor/Payee</b>	<b>Type</b>	<b>Amount</b>
Total (agree to Schedule V, line 19, column 3)		9,433

**Home Office Allocation**

Heyl, Royster, Voelker & Allen	Legal	34
GoffWilson, P.A.	Legal	49
Jackson Lewis	Legal	384
Peter Gartelos	Legal	37
Misc.	Legal	33
Ginoli & Company	Accountants	2,853
Miscellaneous Vendors	Computer Services	36
Emdeon Business Services	Computer Services	16
Advanced Answers on Demand	Computer Services	2,058
Access 2 Go	Computer Services	198
Ivans	Computer Services	23
Kemper Technology	Computer Services	559
VisionShare	Computer Services	174
MediFax	Computer Services	71
LogmeIn	Computer Services	31
Charter Communications	Computer Services	1
Simple LTC	Computer Services	475
Miscellaneous Vendors	Miscellaneous	325
Total (agree to Schedule V, line 19, column 8)		<u>16,790</u>



Facility Name & ID Number Lebanon Care Center# 0049064Report 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? No  
If YES, give association name and amount. 0
- (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. \$ 1,120 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. \$ 49,275  
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. \$ 1,762
- (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.