

Facility Name & ID Number McLeansboro Rehabilitation & Health Care Center

0047498 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	43	Skilled (SNF)	43	15,695	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	43	TOTALS	43	15,695	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	7,798	3,200	1,848	12,846	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,798	3,200	1,848	12,846	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.85%

D. How many bed-hold days during this year were paid by the Department? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 10/1/2005

J. Was the facility purchased or leased after January 1, 1978?
YES Date 10/1/2005 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 43 and days of care provided 1,623

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

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

Facility Name & ID Number McLeansboro Rehabilitation & Health Care (# 0047498 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	102,714	6,466		109,180		109,180	2,246	111,426		1
2	Food Purchase		69,519		69,519		69,519	(2,054)	67,465		2
3	Housekeeping	57,574	11,603		69,177		69,177	21	69,198		3
4	Laundry	16,327	9,258	17	25,602		25,602		25,602		4
5	Heat and Other Utilities			69,648	69,648		69,648	222	69,870		5
6	Maintenance	20,519	6,902	11,467	38,888		38,888	2,346	41,234		6
7	Other (specify):* Home Off. Ben. All.							406	406		7
8	TOTAL General Services	197,134	103,748	81,132	382,014		382,014	3,187	385,201		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	517,825	48,643	16,924	583,392		583,392	1,360	584,752		10
10a	Therapy			200,785	200,785		200,785		200,785		10a
11	Activities	25,013	82	795	25,890		25,890		25,890		11
12	Social Services	27,023		1,340	28,363		28,363		28,363		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.							167	167		15
16	TOTAL Health Care and Programs	569,861	48,725	231,844	850,430		850,430	1,527	851,957		16
	C. General Administration										
17	Administrative	12,500		76,000	88,500		88,500	(36,164)	52,336		17
18	Directors Fees										18
19	Professional Services			9,481	9,481		9,481	4,027	13,508		19
20	Dues, Fees, Subscriptions & Promotions			11,941	11,941		11,941	1,641	13,582		20
21	Clerical & General Office Expenses	31,886	3,442	10,025	45,353		45,353	24,825	70,178		21
22	Employee Benefits & Payroll Taxes			256,832	256,832		256,832		256,832		22
23	Inservice Training & Education			35	35		35	234	269		23
24	Travel and Seminar							72	72		24
25	Other Admin. Staff Transportation			2,729	2,729		2,729	1,355	4,084		25
26	Insurance-Prop.Liab.Malpractice			15,317	15,317		15,317	468	15,785		26
27	Other (specify):* Home Off. Ben. All.							8,853	8,853		27
28	TOTAL General Administration	44,386	3,442	382,360	430,188		430,188	5,311	435,499		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	811,381	155,915	695,336	1,662,632		1,662,632	10,025	1,672,657		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 McLeansboro Rehabilitation & Health Care Center #0047498 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			56,337	56,337		56,337	3,590	59,927			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			32,364	32,364		32,364	16,697	49,061			32
33	Real Estate Taxes			7,343	7,343		7,343	284	7,627			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			11,497	11,497		11,497	272	11,769			35
36	Other (specify):*											36
37	TOTAL Ownership			107,541	107,541		107,541	20,843	128,384			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		56,174		56,174		56,174		56,174			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			23,543	23,543		23,543		23,543			42
43	Other (specify):* Non-allowable Cost		371	58,051	58,422		58,422	(58,422)				43
44	TOTAL Special Cost Centers		56,545	81,594	138,139		138,139	(58,422)	79,717			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	811,381	212,460	884,471	1,908,312		1,908,312	(27,554)	1,880,758			45

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

McLeansboro Rehabilitation & Health Care Center

ID# 0047498

Report Period Beginning: 1/1/2009

Ending: 12/31/2009

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Labs-Part A	\$ (16,815)	43	1
2	X-Rays-Part A	(2,112)	43	2
3	Resident Flowers	(355)	43	3
4	Offset Miscellaneous Office Supplies Revenue	(52)	21	4
5	Offset Chamber of Commerce Dues	(150)	20	5
6	Disallowed Special Events	28	43	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	(19,456)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number McLeansboro Rehabilitation & Health Care Center# 0047498

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	2,246	0	0	0	0	0	0	0	0	0	2,246	1
2	Food Purchase	(2,104)	50	0	0	0	0	0	0	0	0	0	(2,054)	2
3	Housekeeping	0	21	0	0	0	0	0	0	0	0	0	21	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	222	0	0	0	0	0	0	0	0	0	222	5
6	Maintenance	0	1,088	0	1,258	0	0	0	0	0	0	0	2,346	6
7	Other (specify):*	0	406	0	0	0	0	0	0	0	0	0	406	7
8	TOTAL General Services	(2,104)	4,033	0	1,258	0	3,187	8						
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	1,360	0	0	0	0	0	0	0	0	0	1,360	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	167	0	0	0	0	0	0	0	0	0	167	15
16	TOTAL Health Care and Programs	0	1,527	0	0	0	0	0	0	0	0	0	1,527	16
	C. General Administration													
17	Administrative	0	(36,164)	0	0	0	0	0	0	0	0	0	(36,164)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	3,150	0	877	0	0	0	0	0	0	0	4,027	19
20	Fees, Subscriptions & Promotions	(150)	0	878	913	0	0	0	0	0	0	0	1,641	20
21	Clerical & General Office Expenses	(52)	0	22,907	1,970	0	0	0	0	0	0	0	24,825	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	234	0	0	0	0	0	0	0	0	234	23
24	Travel and Seminar	0	0	72	0	0	0	0	0	0	0	0	72	24
25	Other Admin. Staff Transportation	0	0	1,129	226	0	0	0	0	0	0	0	1,355	25
26	Insurance-Prop.Liab.Malpractice	0	0	468	0	0	0	0	0	0	0	0	468	26
27	Other (specify):*	0	0	6,149	2,704	0	0	0	0	0	0	0	8,853	27
28	TOTAL General Administration	(202)	(33,014)	31,837	6,690	0	5,311	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(2,306)	(27,454)	31,837	7,948	0	10,025	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number McLeansboro Rehabilitation & Health Care Center# 0047498

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	955	0	1,852	783	0	0	0	0	0	0	0	3,590	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(381)	0	2,848	14,230	0	0	0	0	0	0	0	16,697	32
33	Real Estate Taxes	0	0	284	0	0	0	0	0	0	0	0	284	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	272	0	0	0	0	0	0	0	0	272	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	574	0	5,256	15,013	0	20,843	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):*	(58,422)	0	0	0	0	0	0	0	0	0	0	(58,422)	43
44	TOTAL Special Cost Centers	(58,422)	0	0	0	0	0	0	0	0	0	0	(58,422)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(60,154)	(27,454)	37,093	22,961	0	0	0	0	0	0	0	(27,554)	45

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 2,246	\$ 2,246	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	50	50	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	21	21	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	222	222	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	1,088	1,088	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	406	406	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	1,360	1,360	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%	167	167	10
11	V	17 Administrative	76,000	Petersen Health Care, Inc.	100.00%	39,836	(36,164)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	3,150	3,150	12
13	V							13
14	Total		\$ 76,000			\$ 48,546	\$ * (27,454)	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%	\$ 878	\$	878	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	22,907		22,907	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	234		234	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	72		72	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	1,129		1,129	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	468		468	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	6,149		6,149	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	1,852		1,852	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	2,848		2,848	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	284		284	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%	272		272	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		\$			\$ 37,093	\$ *	37,093	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1 Dietary	\$	Petersen Health Operations, LLC	100.00%	\$ 0	\$	15	
16	V	2 Food		Petersen Health Operations, LLC	100.00%	0		16	
17	V	3 Housekeeping		Petersen Health Operations, LLC	100.00%	0		17	
18	V	4 Laundry		Petersen Health Operations, LLC	100.00%	0		18	
19	V	5 Utilities		Petersen Health Operations, LLC	100.00%	0		19	
20	V	6 Maintenance		Petersen Health Operations, LLC	100.00%	1,258	1,258	20	
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	0		21	
22	V	10 Nursing and Medical Records		Petersen Health Operations, LLC	100.00%	0		22	
23	V	12 Social Services		Petersen Health Operations, LLC	100.00%	0		23	
24	V	17 Administrative		Petersen Health Operations, LLC	100.00%	0		24	
25	V	19 Professional Services		Petersen Health Operations, LLC	100.00%	877	877	25	
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Operations, LLC	100.00%	913	913	26	
27	V	21 Clerical and General Office		Petersen Health Operations, LLC	100.00%	1,970	1,970	27	
28	V	22 Employee Benefits & Payroll		Petersen Health Operations, LLC	100.00%	0		28	
29	V	23 Inservice Training & Education		Petersen Health Operations, LLC	100.00%	0		29	
30	V	24 Travel and Seminar		Petersen Health Operations, LLC	100.00%	0		30	
31	V	25 Other Admin. Staff Transport.		Petersen Health Operations, LLC	100.00%	226	226	31	
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Operations, LLC	100.00%	0		32	
33	V	27 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	2,704	2,704	33	
34	V	30 Depreciation		Petersen Health Operations, LLC	100.00%	783	783	34	
35	V	32 Interest		Petersen Health Operations, LLC	100.00%	14,230	14,230	35	
36	V	33 Real Estate Taxes		Petersen Health Operations, LLC	100.00%	0		36	
37	V	34 Rent-Facility and Grounds		Petersen Health Operations, LLC	100.00%	0		37	
38	V	35 Rent-Equipment & Vehicles		Petersen Health Operations, LLC	100.00%	0		38	
39	Total		\$			\$ 22,961	\$ *	22,961	39

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

Facility Name & ID Number McLeansboro Rehabilitation & Health Care # 0047498 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Petersen	President	Administrative	100.00	157,652	0.5	0.83	Salary	\$ 1,461	L17, C7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 1,461		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 McLeansboro Rehabilitation & Health Care Center # 0047498 Report Period Beginning: 1/1/2009 Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,493,044	75	\$ 261,102	\$ 259,584	12,846	\$ 2,246	1
2	2	Food	Resident Days	1,493,044	75	5,864	0	12,846	50	2
3	3	Housekeeping	Resident Days	1,493,044	75	2,458	0	12,846	21	3
4	4	Laundry	Resident Days	1,493,044	75	0	0	12,846	0	4
5	5	Utilities	Resident Days	1,493,044	75	25,776	0	12,846	222	5
6	6	Maintenance	Resident Days	1,493,044	75	126,463	107,810	12,846	1,088	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	47,148	0	12,846	406	7
8	10	Nursing and Medical Records	Resident Days	1,493,044	75	158,020	151,697	12,846	1,360	8
9	10A	Therapy	Resident Days	1,493,044	75	0	0	12,846	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	19,462	0	12,846	167	10
11	17	Administrative	Resident Days	1,493,044	75	3,315,953	3,315,953	12,846	39,836	11
12	19	Professional Services	Resident Days	1,493,044	75	366,089	0	12,846	3,150	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,493,044	75	102,022	0	12,846	878	13
14	21	Clerical and General Office	Resident Days	1,493,044	75	2,662,394	2,253,243	12,846	22,907	14
15	23	Inservice Training & Education	Resident Days	1,493,044	75	27,176	0	12,846	234	15
16	24	Travel and Seminar	Resident Days	1,493,044	75	8,381	0	12,846	72	16
17	25	Other Admin. Staff Transport.	Resident Days	1,493,044	75	131,200	0	12,846	1,129	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,493,044	75	54,425	0	12,846	468	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	714,650	0	12,846	6,149	19
20	30	Depreciation	Resident Days	1,493,044	75	215,197	0	12,846	1,852	20
21	32	Interest	Resident Days	1,493,044	75	330,981	0	12,846	2,848	21
22	33	Real Estate Taxes	Resident Days	1,493,044	75	33,065	0	12,846	284	22
23	34	Rent-Facility and Grounds	Resident Days	1,493,044	75	0	0	12,846	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,493,044	75	31,635	0	12,846	272	24
25	TOTALS					\$ 8,639,461	\$ 6,088,287		\$ 85,639	25

Facility Name & ID Number McLeansboro Rehabilitation & Health Care Center # 0047498 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 Operations, LLC
 Street Address 830 W. Trailcreek Drive
 City / State / Zip Code Peoria, IL 61614
 Phone Number (309) 691-8113
 Fax Number (309) 691-8622

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	399,145	21	\$	\$	12,846	\$	1
2	2	Food	Resident Days	399,145	21			12,846		2
3	3	Housekeeping	Resident Days	399,145	21			12,846		3
4	4	Laundry	Resident Days	399,145	21			12,846		4
5	5	Utilities	Resident Days	399,145	21			12,846		5
6	6	Maintenance	Resident Days	399,145	21	39,101		12,846	1,258	6
7	7	Mgmt. Allocation of Benefits	Resident Days	399,145	21			12,846		7
8	10	Nursing and Medical Records	Resident Days	399,145	21			12,846		8
9	12	Social Services	Resident Days	399,145	21			12,846		9
10	17	Administrative	Resident Days	399,145	21			12,846		10
11	19	Professional Services	Resident Days	399,145	21	27,247		12,846	877	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	399,145	21	28,366		12,846	913	12
13	21	Clerical and General Office	Resident Days	399,145	21	61,225		12,846	1,970	13
14	22	Employee Benefits & Payroll	Resident Days	399,145	21			12,846		14
15	23	Inservice Training & Education	Resident Days	399,145	21			12,846		15
16	24	Travel and Seminar	Resident Days	399,145	21			12,846		16
17	25	Other Admin. Staff Transport.	Resident Days	399,145	21	7,018		12,846	226	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	399,145	21			12,846		18
19	27	Mgmt. Allocation of Benefits	Resident Days	399,145	21	84,024		12,846	2,704	19
20	30	Depreciation	Resident Days	399,145	21	24,325		12,846	783	20
21	32	Interest	Resident Days	399,145	21	442,158		12,846	14,230	21
22	33	Real Estate Taxes	Resident Days	399,145	21			12,846		22
23	34	Rent-Facility and Grounds	Resident Days	399,145	21			12,846		23
24	35	Rent-Equipment & Vehicles	Resident Days	399,145	21			12,846		24
25	TOTALS					\$ 713,464	\$		\$ 22,961	25

Facility Name & ID Number

McLeansboro Rehabilitation & Health Care C

0047498

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Bank of America		X	Mortgage	Varies	1/19/07	\$ 650,000	\$ 630,223	12/31/13	Varies	\$ 32,364	1								
2												2								
3							Interest Income Offset				(381)	3								
4							Home Office Allocation-PHC				2,848	4								
5							Home Office Allocation-PHO				14,230	5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related						\$ 650,000	\$ 630,223			\$ 49,061	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 650,000	\$ 630,223			\$ 49,061	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 11,840 B. General Construction Type: Exterior Brick Frame Fire Resistant 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>56,628</u>	<u>2005</u>	<u>\$ 40,500</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	56,628		\$ 40,500	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	73		2005	1973	\$ 727,500	\$	25	\$ 29,100	\$ 29,100	\$ 130,950
5										
6										
7										
8										
	Improvement Type**									
9		Original Land Improvements	2005		14,000		15	933	933	4,199
10		Water Tap	2007		2,500		15	167	167	417
11		Sprinkler System	2007		39,152		15	2,610	2,610	6,525
12		Grease Trap	2007		4,075		15	272	272	680
13		Drain Tank	2007		462		15	31	31	77
14		Fire Alarm	2007		4,283		15	286	286	715
15		Roof repair	2008		7,639		25	306	306	459
16										
17										
18										
19										
20										
21										
22										
23										
24										
25										
26										
27		Land Improvements Booked				1,100			(1,100)	
28		Building Booked				29,185			(29,185)	
29		Building Improvement Booked				2,910			(2,910)	
30										
31										
32		2009-Home Office Allocation-Land Improvements			423			27	27	
33		2009-Home Office Allocation-Building Improvements			6,315			151	151	
34										
35										
36										

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number **McLeansboro Rehabilitation & Health Care Center**

0047498

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

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)		\$ 806,349	\$ 33,195		\$ 33,883	\$ 688	\$ 144,022	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 162,394	\$ 22,978	\$ 22,902	\$ (76)	7-10 yrs.	\$ 101,049	71
72	Current Year Purchases	10,148	164	507	343	10 yrs.	507	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			2,635	2,635			74
75	TOTALS	\$ 172,542	\$ 23,142	\$ 26,044	\$ 2,902		\$ 101,556	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)	\$ 1,019,391	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 56,337	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 59,927	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 3,590	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 245,578	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: \$ 4,831 Description: See Attached Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____/2010 \$ _____

13. _____/2011 \$ _____

14. _____/2012 \$ _____

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

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

McLeansboro Rehabilitation & Health Care Center
0047498
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	\$	692
Dishwasher		708
Maintenance Equipment		25
Copier		3,134
Home Office Allocation		272
		<u>4,831</u>

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	5,703	\$ 85,551	\$	5,703	\$ 85,551	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,311	19,676		1,311	19,676	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		6,371	95,558		6,371	95,558	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				56,174		56,174	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			\$	13,385	\$ 200,785	\$ 56,174	13,385	\$ 256,959	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 **McLeansboro Rehabilitation & Health Care Center**

0047498

Report Period Beginning: **1/1/2009**

Ending: **12/31/2009**

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2009** (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 117,209	\$ 117,209	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>10,000</u>)	276,048	276,048	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	21,806	21,806	6
7	Other Prepaid Expenses	7,186	7,186	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Prepaid Mgmt. Fees</u>	13,000	13,000	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 435,249	\$ 435,249	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	57,000	40,500	13
14	Buildings, at Historical Cost	727,500	733,815	14
15	Leasehold Improvements, at Historical Cost	55,611	72,534	15
16	Equipment, at Historical Cost	172,542	172,542	16
17	Accumulated Depreciation (book methods)	(232,246)	(245,578)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 780,407	\$ 773,813	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,215,656	\$ 1,209,062	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 305,260	\$ 305,260	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	15,574	15,574	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,647	2,647	31
32	Accrued Real Estate Taxes(Sch.IX-B)	7,500	7,500	32
33	Accrued Interest Payable	2,822	2,822	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Payroll Withholdings</u>	31,135	31,135	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 364,938	\$ 364,938	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	630,223	630,223	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)	\$ 630,223	\$ 630,223	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 995,161	\$ 995,161	46
47	TOTAL EQUITY(page 18, line 24)	\$ 220,495	\$ 213,901	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,215,656	\$ 1,209,062	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 300,531	1
2	Restatements (describe):		2
3	2008 Bad Debt Allowance Entered After CR Completion	(10,000)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 290,531	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(70,036)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (70,036)	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)	\$ 220,495	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number McLeansboro Rehabilitation & Health Care Center # 0047498 Report Period Beginning: 1/1/2009Ending: 12/31/2009**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.****Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 1,448,030	1
2	Discounts and Allowances for all Levels	(62,233)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,385,797	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	312,015	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 312,015	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,104	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	93,859	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	41,958	20
21	Other Medical Services	2,110	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 140,031	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	381	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 381	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Revenue</u>	52	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 52	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,838,276	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	382,014	31
32	Health Care	850,430	32
33	General Administration	430,188	33
B. Capital Expense			
34	Ownership	107,541	34
C. Ancillary Expense			
35	Special Cost Centers	114,596	35
36	Provider Participation Fee	23,543	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,908,312	40
41	Income before Income Taxes (line 30 minus line 40)**	(70,036)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (70,036)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. Facility is part of larger entity.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **McLeansboro Rehabilitation & Health Care Center**

0047498

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	1,898	1,913	\$ 39,734	\$ 20.77	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,340	3,483	69,598	19.98	3
4	Licensed Practical Nurses	9,615	9,842	146,270	14.86	4
5	CNAs & Orderlies	27,499	27,882	252,388	9.05	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,081	2,088	22,710	10.88	9
10	Activity Assistants	256	256	2,303	9.00	10
11	Social Service Workers	2080	2,080	27,023	12.99	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	25,037	12.04	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,713	9,125	77,677	8.51	15
16	Dishwashers					16
17	Maintenance Workers	1,706	1,729	20,519	11.87	17
18	Housekeepers	6,464	6,627	57,574	8.69	18
19	Laundry	1,918	2,014	16,327	8.11	19
20	Administrator	2,080	2,080	50,875	24.46	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,047	2,221	31,886	14.36	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Care Plan Coord.</u>	528	551	9,835	17.85	33
34	TOTAL (lines 1 - 33)	72,305	73,971	\$ 849,756 *	\$ 11.49	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	12,000	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	600	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	Monthly	1,340	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 13,940		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	33	\$ 1,005	10(3)	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	33	\$ 1,005		53

McLeansboro Rehabilitation & Health Care Center

0047498

Period Beginning 1/1/2009

Period End 12/31/2009

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		9,481

Home Office Allocation

Heyl, Royster, Voelker & Allen	Legal	(10)
GoffWilson, P.A.	Legal	29
Jackson Lewis	Legal	226
Peter Gartelos	Legal	22
Misc.	Legal	19
Ginoli & Company	Accountants	1,358
Miscellaneous Vendors	Computer Services	21
Emdeon Business Services	Computer Services	9
Advanced Answers on Demand	Computer Services	1,210
Access 2 Go	Computer Services	116
Ivans	Computer Services	63
Kemper Technology	Computer Services	329
VisionShare	Computer Services	102
MediFax	Computer Services	42
LogmeIn	Computer Services	18
Charter Communications	Computer Services	1
Simple LTC	Computer Services	279
Miscellaneous Vendors	Miscellaneous	193
Total (agree to Schedule V, line 19, column 8)		<u>13,508</u>

Facility Name & ID Number McLeansboro Rehabilitation & Health Care Center# 0047498Report Period Beginning: 1/1/2009Ending: 12/31/2009**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. 1,500 IHCA
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? No
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 10,921 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. \$ 23,543
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. \$ 2,104
- (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.