

Facility Name & ID Number Pleasant View Rehab & HCC

0050203 Report Period Beginning: 4/1/2009 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	8	Skilled (SNF)	8	2,200	1
2		Skilled Pediatric (SNF/PED)			2
3	66	Intermediate (ICF)	66	18,150	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	74	TOTALS	74	20,350	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF			568	568	8	
9	SNF/PED					9	
10	ICF	8,624	4,751	110	13,485	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	8,624	4,751	678	14,053	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.06%

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 4/1/2009

J. Was the facility purchased or leased after January 1, 1978?
YES Date 4/1/2009 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 8 and days of care provided 568

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 Pleasant View Rehab & HCC # 0050203 Report Period Beginning: 4/1/2009 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	105,527	7,285		112,812		112,812	2,458	115,270		1
2	Food Purchase		80,750		80,750		80,750	(4,208)	76,542		2
3	Housekeeping	53,439	14,948		68,387		68,387	23	68,410		3
4	Laundry	20,068	9,313		29,381		29,381		29,381		4
5	Heat and Other Utilities			49,909	49,909		49,909	243	50,152		5
6	Maintenance	33,707	8,465	13,295	55,467		55,467	1,190	56,657		6
7	Other (specify):* Home Off. Ben. All.							444	444		7
8	TOTAL General Services	212,741	120,761	63,204	396,706		396,706	150	396,856		8
	B. Health Care and Programs										
9	Medical Director			19,600	19,600		19,600		19,600		9
10	Nursing and Medical Records	701,715	43,083	19,481	764,279		764,279	1,259	765,538		10
10a	Therapy			94,279	94,279		94,279		94,279		10a
11	Activities	32,311	11		32,322		32,322	(1,229)	31,093		11
12	Social Services	22,007		3,187	25,194		25,194		25,194		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.							183	183		15
16	TOTAL Health Care and Programs	756,033	43,094	136,547	935,674		935,674	213	935,887		16
	C. General Administration										
17	Administrative			138,000	138,000		138,000	(97,069)	40,931		17
18	Directors Fees										18
19	Professional Services			3,304	3,304		3,304	3,446	6,750		19
20	Dues, Fees, Subscriptions & Promotions			3,230	3,230		3,230	973	4,203		20
21	Clerical & General Office Expenses	20,297	7,297	10,128	37,722		37,722	25,570	63,292		21
22	Employee Benefits & Payroll Taxes			107,819	107,819		107,819		107,819		22
23	Inservice Training & Education			500	500		500	256	756		23
24	Travel and Seminar							79	79		24
25	Other Admin. Staff Transportation			3,183	3,183		3,183	1,235	4,418		25
26	Insurance-Prop.Liab.Malpractice			16,175	16,175		16,175	512	16,687		26
27	Other (specify):* Home Off. Ben. All.							6,726	6,726		27
28	TOTAL General Administration	20,297	7,297	282,339	309,933		309,933	(58,272)	251,661		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	989,071	171,152	482,090	1,642,313		1,642,313	(57,909)	1,584,404		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 Pleasant View Rehab & HCC

#0050203

Report Period Beginning:

4/1/2009

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			568	568		568	41,977	42,545			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			5,228	5,228		5,228	99,811	105,039			32
33	Real Estate Taxes							27,311	27,311			33
34	Rent-Facility & Grounds			125,307	125,307		125,307	(125,307)				34
35	Rent-Equipment & Vehicles			1,758	1,758		1,758	298	2,056			35
36	Other (specify):*											36
37	TOTAL Ownership			132,861	132,861		132,861	44,090	176,951			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		21,692		21,692		21,692		21,692			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			30,525	30,525		30,525		30,525			42
43	Other (specify):* Non-allowable Cost		453	45,665	46,118		46,118	(46,118)				43
44	TOTAL Special Cost Centers		22,145	76,190	98,335		98,335	(46,118)	52,217			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	989,071	193,297	691,141	1,873,509		1,873,509	(59,937)	1,813,572			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,263)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,107)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(19,836)	30		9
10	Interest and Other Investment Income	(4,018)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(263)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(5,745)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(28,762)	43		24
25	Fund Raising, Advertising and Promotional	(2,023)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg. 5A	(8,249)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (76,266)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	16,329	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 16,329		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (59,937)		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

Pleasant View Rehab & HCC

ID# 0050203

Report Period Beginning: 4/1/2009

Ending: 12/31/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (3,007)	43	1
2	X-Rays-Part A	(725)	43	2
3	Offset Miscellaneous Nursing Supplies Revenue	(228)	10	3
4	Disallowed Pet Expense	(941)	43	4
5	Offset Miscellaneous Office Supplies Revenue	(124)	21	5
6	Offset Transportation Revenue	(1,229)	11	6
7	Resident Flowers	(450)	43	7
8	Disallowed Special Events	(1,095)	43	8
9	Disallowed Chamber of Commerce Dues	(450)	20	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	(8,249)		49

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 2,458	\$ 2,458	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	55	55	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	23	23	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	243	243	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	1,190	1,190	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	444	444	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	1,487	1,487	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%	183	183	10
11	V	17 Administrative	138,000	Petersen Health Care, Inc.	100.00%	40,931	(97,069)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	3,446	3,446	12
13	V							13
14	Total		\$ 138,000			\$ 50,460	\$ * (87,540)	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%	\$ 960	\$	960	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	25,059		25,059	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	256		256	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	79		79	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	1,235		1,235	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	512		512	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	6,726		6,726	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	2,026		2,026	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	3,115		3,115	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	311		311	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%	298		298	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		\$			\$ 40,577	\$ *	40,577	39

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

Facility Name & ID Number Pleasant View Rehab & HCC

0050203

Report Period Beginning: 4/1/2009

Ending: 12/31/2009

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1 Dietary	\$	Petersen Health Operations III, LLC	100.00%	\$ 0	\$	15	
16	V	2 Food		Petersen Health Operations III, LLC	100.00%	0		16	
17	V	3 Housekeeping		Petersen Health Operations III, LLC	100.00%	0		17	
18	V	4 Laundry		Petersen Health Operations III, LLC	100.00%	0		18	
19	V	5 Utilities		Petersen Health Operations III, LLC	100.00%	0		19	
20	V	6 Maintenance		Petersen Health Operations III, LLC	100.00%	0		20	
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Operations III, LLC	100.00%	0		21	
22	V	10 Nursing and Medical Records		Petersen Health Operations III, LLC	100.00%	0		22	
23	V	10A Therapy		Petersen Health Operations III, LLC	100.00%	0		23	
24	V	15 Mgmt. Allocation of Benefits		Petersen Health Operations III, LLC	100.00%	0		24	
25	V	17 Administrative		Petersen Health Operations III, LLC	100.00%	0		25	
26	V	19 Professional Services		Petersen Health Operations III, LLC	100.00%	0		26	
27	V	20 Dues, Fees, Subs & Promotions		Petersen Health Operations III, LLC	100.00%	463	463	27	
28	V	21 Clerical and General Office		Petersen Health Operations III, LLC	100.00%	635	635	28	
29	V	23 Inservice Training & Education		Petersen Health Operations III, LLC	100.00%	0		29	
30	V	24 Travel and Seminar		Petersen Health Operations III, LLC	100.00%	0		30	
31	V	25 Other Admin. Staff Transport.		Petersen Health Operations III, LLC	100.00%	0		31	
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Operations III, LLC	100.00%	0		32	
33	V	27 Mgmt. Allocation of Benefits		Petersen Health Operations III, LLC	100.00%	0		33	
34	V	30 Depreciation		Petersen Health Operations III, LLC	100.00%	0		34	
35	V	32 Interest		Petersen Health Operations III, LLC	100.00%	0		35	
36	V	33 Real Estate Taxes		Petersen Health Operations III, LLC	100.00%	0		36	
37	V	34 Rent-Facility and Grounds		Petersen Health Operations III, LLC	100.00%	0		37	
38	V	35 Rent-Equipment & Vehicles		Petersen Health Operations III, LLC	100.00%	0		38	
39	Total		\$			\$ 1,098	\$ *	1,098	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	30 Depreciation	\$	Petersen Companies III, LLC	100.00%	\$ 59,787	\$ 59,787	15
16	V	32 Interest		Petersen Companies III, LLC	100.00%	100,714	100,714	16
17	V	33 Real Estate Taxes		Petersen Companies III, LLC	100.00%	27,000	27,000	17
18	V	34 Rent-Facility and Grounds	125,307	Petersen Companies III, LLC	100.00%		(125,307)	18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							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		\$ 125,307			\$ 187,501	\$ * 62,194	39

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

Facility Name & ID Number

Pleasant View Rehab & HCC

0050203

Report Period Beginning:

4/1/2009

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	157,515	0.55	0.91	Salary	\$ 1,598	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	\$ 1,598		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 Pleasant View Rehab & HCC# 0050203

Report Period Beginning:

4/1/2009Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

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	14,053	\$ 2,458	1
2	2	Food	Resident Days	1,493,044	75	5,864	0	14,053	55	2
3	3	Housekeeping	Resident Days	1,493,044	75	2,458	0	14,053	23	3
4	4	Laundry	Resident Days	1,493,044	75	0	0	14,053	0	4
5	5	Utilities	Resident Days	1,493,044	75	25,776	0	14,053	243	5
6	6	Maintenance	Resident Days	1,493,044	75	126,463	107,810	14,053	1,190	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	47,148	0	14,053	444	7
8	10	Nursing and Medical Records	Resident Days	1,493,044	75	158,020	151,697	14,053	1,487	8
9	10A	Therapy	Resident Days	1,493,044	75	0	0	14,053	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	19,462	0	14,053	183	10
11	17	Administrative	Resident Days	1,493,044	75	3,315,953	3,315,953	14,053	40,931	11
12	19	Professional Services	Resident Days	1,493,044	75	366,089	0	14,053	3,446	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,493,044	75	102,022	0	14,053	960	13
14	21	Clerical and General Office	Resident Days	1,493,044	75	2,662,394	2,253,243	14,053	25,059	14
15	23	Inservice Training & Education	Resident Days	1,493,044	75	27,176	0	14,053	256	15
16	24	Travel and Seminar	Resident Days	1,493,044	75	8,381	0	14,053	79	16
17	25	Other Admin. Staff Transport.	Resident Days	1,493,044	75	131,200	0	14,053	1,235	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,493,044	75	54,425	0	14,053	512	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	714,650	0	14,053	6,726	19
20	30	Depreciation	Resident Days	1,493,044	75	215,197	0	14,053	2,026	20
21	32	Interest	Resident Days	1,493,044	75	330,981	0	14,053	3,115	21
22	33	Real Estate Taxes	Resident Days	1,493,044	75	33,065	0	14,053	311	22
23	34	Rent-Facility and Grounds	Resident Days	1,493,044	75	0	0	14,053	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,493,044	75	31,635	0	14,053	298	24
25	TOTALS					\$ 8,639,461	\$ 6,088,287		\$ 91,037	25

Facility Name & ID Number Pleasant View Rehab & HCC

0050203

Report Period Beginning:

4/1/2009

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	31,953	2	\$	\$	14,053	\$	1
2	2	Food	Resident Days	31,953	2			14,053		2
3	3	Housekeeping	Resident Days	31,953	2			14,053		3
4	4	Laundry	Resident Days	31,953	2			14,053		4
5	5	Utilities	Resident Days	31,953	2			14,053		5
6	6	Maintenance	Resident Days	31,953	2			14,053		6
7	7	Mgmt. Allocation of Benefits	Resident Days	31,953	2			14,053		7
8	10	Nursing and Medical Records	Resident Days	31,953	2			14,053		8
9	10A	Therapy	Resident Days	31,953	2			14,053		9
10	15	Mgmt. Allocation of Benefits	Resident Days	31,953	2			14,053		10
11	17	Administrative	Resident Days	31,953	2			14,053		11
12	19	Professional Services	Resident Days	31,953	2			14,053		12
13	20	Dues, Fees, Subs & Promotions	Resident Days	31,953	2	1,053		14,053	463	13
14	21	Clerical and General Office	Resident Days	31,953	2	1,443		14,053	635	14
15	23	Inservice Training & Education	Resident Days	31,953	2			14,053		15
16	24	Travel and Seminar	Resident Days	31,953	2			14,053		16
17	25	Other Admin. Staff Transport.	Resident Days	31,953	2			14,053		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	31,953	2			14,053		18
19	27	Mgmt. Allocation of Benefits	Resident Days	31,953	2			14,053		19
20	30	Depreciation	Resident Days	31,953	2			14,053		20
21	32	Interest	Resident Days	31,953	2			14,053		21
22	33	Real Estate Taxes	Resident Days	31,953	2			14,053		22
23	34	Rent-Facility and Grounds	Resident Days	31,953	2			14,053		23
24	35	Rent-Equipment & Vehicles	Resident Days	31,953	2			14,053		24
25	TOTALS					\$ 2,496	\$		\$ 1,098	25

Facility Name & ID Number Pleasant View Rehab & HCC

0050203

Report Period Beginning:

4/1/2009

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 Companies III, LLC
 Street Address 830 W. Trailcreek Dr.
 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	30	Depreciation	Direct Cost	148,737	1	\$ 148,737	\$ 59,787	\$ 59,787	1
2	32	Interest	Direct Cost	243,516	1	243,516	100,714	100,714	2
3	33	Real Estate Taxes	Direct Cost	57,536	1	57,536	27,000	27,000	3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 449,789	\$	\$ 187,501	25

Facility Name & ID Number

Pleasant View Rehab & HCC

0050203

Report Period Beginning:

4/1/2009

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			
A. Directly Facility Related																			
Long-Term																			
1	First Merit		X	Mortgage	Varies	4/1/09	\$ 1,725,000	\$ 1,707,352	3/25/12	0.0675	\$ 90,537	1							
2												2							
3							Interest Income Offset				(4,018)	3							
4							Home Office Allocation-PHC				3,115	4							
5												5							
Working Capital																			
6	First Merit		X	LOC	Varies	4/1/09	400,000	153,745	3/25/12	Varies	5,228	6							
7												7							
8												8							
9	TOTAL Facility Related						\$ 2,125,000	\$ 1,861,097			\$ 94,862	9							
B. Non-Facility Related*																			
10							Amortization Expense				10,177	10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$ 10,177	14							
15	TOTALS (line 9+line14)						\$ 2,125,000	\$ 1,861,097			\$ 105,039	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: 23,743 B. General Construction Type: Exterior Brick Frame Metal Number of Stories 1

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

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

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

N/A

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>23,743</u>	<u>2009</u>	<u>\$ 183,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	23,743		\$ 183,000	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	74		2009	1974	\$ 992,911	\$	25	\$ 19,858	\$ 19,858	\$ 19,858
5										
6										
7										
8										
	Improvement Type**									
9										
10										
11										
12										
13										
14										
15										
16										
17										
18										
19										
20										
21										
22										
23										
24										
25										
26										
27										
28	Building Booked									
29										
30										
31										
32	2009-Home Office Allocation-Land Improvements				462			29	29	
33	2009-Home Office Allocation-Building Improvements				6,908			166	166	
34										
35										
36										

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9					
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation					
37		\$	\$		\$	\$	\$	37				
38								38				
39								39				
40								40				
41								41				
42								42				
43								43				
44								44				
45								45				
46								46				
47								47				
48								48				
49								49				
50								50				
51								51				
52								52				
53								53				
54								54				
55								55				
56								56				
57								57				
58								58				
59								59				
60								60				
61								61				
62								62				
63								63				
64								64				
65								65				
66								66				
67								67				
68								68				
69								69				
70	TOTAL (lines 4 thru 69)	\$	1,000,281	\$		\$	20,053	\$	20,053	\$	19,858	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	\$	\$	\$	\$		\$	71
72	Current Year Purchases	286,518	568	20,466	19,898	7 yrs.	20,466	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			2,026	2,026			74
75	TOTALS	\$ 286,518	\$ 568	\$ 22,492	\$ 21,924		\$ 20,466	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)	\$ 1,469,799	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 568	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 42,545	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 41,977	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 40,324	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: \$ 2,056 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			\$ _____	\$ _____	17
18			<u>N/A</u>		18
19					19
20					20
21	TOTAL		\$ _____	\$ _____	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

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

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

Pleasant View Rehab & HCC

0050203

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	\$	698
Copier		1,060
Home Office Allocation		298
		<u>2,056</u>

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	1,751	\$ 26,272	\$	1,751	\$ 26,272	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		584	8,760		584	8,760	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		3,950	59,247		3,950	59,247	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				21,692		21,692	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			\$	6,285	\$ 94,279	\$ 21,692	6,285	\$ 115,971	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 Pleasant View Rehab & HCC

0050203

Report Period Beginning: 4/1/2009

Ending: 12/31/2009

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2009

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ (29,483)	\$ (29,483)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>N/A</u>)	181,353	181,353	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	36,889	36,889	6
7	Other Prepaid Expenses	8,197	8,197	7
8	Accounts Receivable (owners or related parties)	250,000	250,000	8
9	Other(specify): <u>Employee Advances</u>	858	858	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 447,814	\$ 447,814	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		183,000	13
14	Buildings, at Historical Cost		999,819	14
15	Leasehold Improvements, at Historical Cost		462	15
16	Equipment, at Historical Cost	6,518	286,518	16
17	Accumulated Depreciation (book methods)	(568)	(40,324)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		40,708	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(10,177)	20
21	Restricted Funds			21
22	Other Long-Term Assets (spe <u>Goodwill</u>)		650,000	22
23	Other(specify): <u>Intercompany-PC III</u>	284,593		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 290,543	\$ 2,110,006	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 738,357	\$ 2,557,820	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 246,693	\$ 246,693	26
27	Officer's Accounts Payable	(556,000)	(556,000)	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	153,745	153,745	29
30	Accrued Salaries Payable	52,657	52,657	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,706	3,706	31
32	Accrued Real Estate Taxes(Sch.IX-B)		38,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Payroll Withholdings</u>	56,418	56,418	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ (42,781)	\$ (4,781)	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,707,352	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>A/P-Prior Owner</u>	12,609	12,609	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 12,609	\$ 1,719,961	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ (30,172)	\$ 1,715,180	46
47	TOTAL EQUITY(page 18, line 24)	\$ 768,529	\$ 842,640	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 738,357	\$ 2,557,820	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	92,949	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	675,580	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)	\$ 768,529	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)	\$ 768,529	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Pleasant View Rehab & HCC

0050203

Report Period Beginning: 4/1/2009

Ending: 12/31/2009

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1		2	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 1,787,073	1
2	Discounts and Allowances for all Levels	(15,431)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,771,642	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	137,803	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 137,803	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	4,263	14
15	Telephone, Television and Radio	1,920	15
16	Rental of Facility Space		16
17	Sale of Drugs	33,581	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	6,339	20
21	Other Medical Services	5,311	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 51,414	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	4,018	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,018	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	352	28
28a	Transportation Revenue	1,229	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,581	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,966,458	30

1		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	396,706	31
32	Health Care	935,674	32
33	General Administration	309,933	33
B. Capital Expense			
34	Ownership	132,861	34
C. Ancillary Expense			
35	Special Cost Centers	67,810	35
36	Provider Participation Fee	30,525	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,873,509	40
41	Income before Income Taxes (line 30 minus line 40)**	92,949	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 92,949	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 Pleasant View Rehab & HCC

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Report Period Beginning:

4/1/2009

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	1,560	1,560	\$ 48,362	\$ 31.00	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,569	2,716	61,578	22.67	3
4	Licensed Practical Nurses	9,792	10,061	215,477	21.42	4
5	CNAs & Orderlies	31,719	32,379	331,577	10.24	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,476	1,500	16,881	11.25	9
10	Activity Assistants	1,395	1,403	11,430	8.15	10
11	Social Service Workers	1352	1,396	22,007	15.76	11
12	Dietician					12
13	Food Service Supervisor	1,560	1,560	19,500	12.50	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,026	10,192	86,027	8.44	15
16	Dishwashers					16
17	Maintenance Workers	2,493	2,551	33,707	13.21	17
18	Housekeepers	5,738	5,901	53,439	9.06	18
19	Laundry	2,406	2,455	20,068	8.17	19
20	Administrator	1,560	1,560	39,333	25.21	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,597	1,701	20,297	11.93	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) See Page 20A	2,836	2,912	48,721	16.73	33
34	TOTAL (lines 1 - 33)	78,079	79,847	\$ 1,028,404 *	\$ 12.88	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	19,600	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	450	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	3,187	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 23,237		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	534	\$ 18,611	10(3)	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	534	\$ 18,611		53

Pleasant View Rehab & HCC

0050203

Period Beginning 1/1/2009

Period End 12/31/2009

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	1,205	1,265	30,118	23.81
Certified Medical Technician	1,147	1,163	14,603	12.56
Transportation	484	484	4,000	8.26
TOTAL (lines 1 - 35)	<u>2,836</u>	<u>2,912</u>	<u>48,721</u>	

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	
Rhonda Biller	Adminstrator	0	\$ 39,333	Workers' Compensation Insurance	\$ 2,276	IDPH License Fee	\$	
				Unemployment Compensation Insurance	22,400	Advertising: Employee Recruitment	1,182	
				FICA Taxes	73,715	Health Care Worker Background Check		
				Employee Health Insurance	8,936	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks	126	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	338	
				Employee Relations	465	Miscellaneous Dues & Subscriptions	450	
				Employee Retirement	27	IHCA Dues		
						Home Office Allocation	960	
TOTAL (agree to Schedule V, line 17, col. 1)						Less: Public Relations Expense	(450)	
(List each licensed administrator separately.)			\$ 39,333			Non-allowable advertising	()	
						Yellow page advertising	()	
B. Administrative - Other						TOTAL (agree to Sch. V, line 20, col. 8)		
Description			Amount			\$ 3,740		
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 138,000					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 138,000					
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type	Amount	Description	Line #	Amount	Description	Amount	
E-Health Data Solutions	Computer Services	\$ 1,350				Out-of-State Travel	\$	
LTC Solutions	Computer Services	1,700						
MDI Achieve	Reversal of Invoice	(732)						
Mediacom	Computer Services	905	N/A			In-State Travel		
SimpleLTC, Inc.	Computer Services	81						
						Seminar Expense		
						Home Office Allocation	79	
						Entertainment Expense	()	
						(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL	\$	TOTAL	\$ 79	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 3,304					

* Attach copy of IMRF notifications

**See instructions.

Pleasant View Rehab & HCC

0050203

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)		3,304

Home Office Allocation

Heyl, Royster, Voelker & Allen	Legal	22
GoffWilson, P.A.	Legal	31
Jackson Lewis	Legal	247
Peter Gartelos	Legal	24
Misc.	Legal	21
Ginoli & Company	Accountants	548
Miscellaneous Vendors	Computer Services	23
Emdeon Business Services	Computer Services	10
Advanced Answers on Demand	Computer Services	1,324
Access 2 Go	Computer Services	127
Ivans	Computer Services	15
Kemper Technology	Computer Services	360
VisionShare	Computer Services	112
MediFax	Computer Services	46
LogmeIn	Computer Services	20
Charter Communications	Computer Services	1
Simple LTC	Computer Services	305
Miscellaneous Vendors	Miscellaneous	210
Total (agree to Schedule V, line 19, column 8)		<u>6,750</u>

Facility Name & ID Number Pleasant View Rehab & HCC

0050203

Report Period Beginning: 4/1/2009

Ending: 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. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? No
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 6,818 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. \$ 30,525
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. \$ 4,263
- (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.