

Facility Name & ID Number Polo Rehabilitation & Health Care Center

0049163 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	81	Skilled (SNF)	81	29,565	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	81	TOTALS	81	29,565	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF	8,212	7,298	2,579	18,089	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,212	7,298	2,579	18,089	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 61.18%

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 2/1/2008

J. Was the facility purchased or leased after January 1, 1978?
YES Date 2/1/2008 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 81 and days of care provided 2,013

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number Polo Rehabilitation & Health Care Center # 0049163 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	148,900	13,785		162,685		162,685	3,163	165,848		1
2	Food Purchase		96,745		96,745		96,745	(9,294)	87,451		2
3	Housekeeping	86,625	21,702		108,327		108,327	30	108,357		3
4	Laundry	21,728	13,940		35,668		35,668		35,668		4
5	Heat and Other Utilities			77,042	77,042		77,042	312	77,354		5
6	Maintenance	44,086	10,469	17,179	71,734		71,734	1,532	73,266		6
7	Other (specify):* <u>Home Off. Ben. All.</u>							571	571		7
8	TOTAL General Services	301,339	156,641	94,221	552,201		552,201	(3,686)	548,515		8
	B. Health Care and Programs										
9	Medical Director			11,300	11,300		11,300		11,300		9
10	Nursing and Medical Records	821,199	40,479	11,128	872,806		872,806	(872)	871,934		10
10a	Therapy	343	7	196,947	197,297		197,297		197,297		10a
11	Activities	56,405	162	557	57,124		57,124		57,124		11
12	Social Services	29,943			29,943		29,943		29,943		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Off. Ben. All.</u>							236	236		15
16	TOTAL Health Care and Programs	907,890	40,648	219,932	1,168,470		1,168,470	(636)	1,167,834		16
	C. General Administration										
17	Administrative	16,875		220,000	236,875		236,875	(167,118)	69,757		17
18	Directors Fees										18
19	Professional Services			5,406	5,406		5,406	7,229	12,635		19
20	Dues, Fees, Subscriptions & Promotions			9,527	9,527		9,527	956	10,483		20
21	Clerical & General Office Expenses	22,847	8,889	11,977	43,713		43,713	35,079	78,792		21
22	Employee Benefits & Payroll Taxes			119,841	119,841		119,841		119,841		22
23	Inservice Training & Education			30	30		30	329	359		23
24	Travel and Seminar							102	102		24
25	Other Admin. Staff Transportation			9,984	9,984		9,984	1,590	11,574		25
26	Insurance-Prop.Liab.Malpractice			26,964	26,964		26,964	659	27,623		26
27	Other (specify):* <u>Home Off. Ben. All.</u>							8,658	8,658		27
28	TOTAL General Administration	39,722	8,889	403,729	452,340		452,340	(112,516)	339,824		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,248,951	206,178	717,882	2,173,011		2,173,011	(116,838)	2,056,173		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 Polo Rehabilitation & Health Care Center

#0049163

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			82,784	82,784		82,784	(24,667)	58,117			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			72,371	72,371		72,371	9,860	82,231			32
33	Real Estate Taxes			37,082	37,082		37,082	401	37,483			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			12,564	12,564		12,564	383	12,947			35
36	Other (specify):*											36
37	TOTAL Ownership			204,801	204,801		204,801	(14,023)	190,778			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		52,802		52,802		52,802		52,802			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			44,348	44,348		44,348		44,348			42
43	Other (specify):* Non-allowable Cost	25,611	192	92,322	118,125		118,125	(78,125)	40,000			43
44	TOTAL Special Cost Centers	25,611	52,994	136,670	215,275		215,275	(78,125)	137,150			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,274,562	259,172	1,059,353	2,593,087		2,593,087	(208,986)	2,384,101			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	(9,365)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,141)	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	(27,274)	30		9
10	Interest and Other Investment Income	(2,204)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(559)	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	(285)	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	(39,036)	43		24
25	Fund Raising, Advertising and Promotional	(26,873)	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	(12,531)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (120,268)		\$	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)	(88,718)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (88,718)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (208,986)		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

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (5,838)	43	1
2	X-Rays-Part A	(1,741)	43	2
3	Offset Miscellaneous Nursing Supplies Revenue	(2,786)	10	3
4	Disallowed Special Events	(125)	43	4
5	Offset Miscellaneous Office Supplies Revenue	(124)	21	5
6	Resident Flowers	(533)	43	6
7	Pet Expense	(994)	43	7
8	Disallowed Dues	(390)	20	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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21				21
22				22
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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	(12,531)		49

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 3,163	\$ 3,163	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	71	71	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	30	30	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	312	312	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	1,532	1,532	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	571	571	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	1,914	1,914	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%	236	236	10
11	V	17 Administrative	220,000	Petersen Health Care, Inc.	100.00%	52,882	(167,118)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	4,435	4,435	12
13	V							13
14	Total		\$ 220,000			\$ 65,146	\$ * (154,854)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	20 Dues, Fees, Subs and Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 1,236	\$	1,236	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	32,256		32,256	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	329		329	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	102		102	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	1,590		1,590	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	659		659	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	8,658		8,658	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	2,607		2,607	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	4,010		4,010	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	401		401	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%	383		383	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		\$			\$ 52,231	\$ *	52,231	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 Care V, LLC	100.00%	\$ 0	\$	15	
16	V	2 Food		Petersen Health Care V, LLC	100.00%	0		16	
17	V	3 Housekeeping		Petersen Health Care V, LLC	100.00%	0		17	
18	V	4 Laundry		Petersen Health Care V, LLC	100.00%	0		18	
19	V	5 Utilities		Petersen Health Care V, LLC	100.00%	0		19	
20	V	6 Maintenance		Petersen Health Care V, LLC	100.00%	0		20	
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Care V, LLC	100.00%	0		21	
22	V	10 Nursing and Medical Records		Petersen Health Care V, LLC	100.00%	0		22	
23	V	10A Therapy		Petersen Health Care V, LLC	100.00%	0		23	
24	V	15 Mgmt. Allocation of Benefits		Petersen Health Care V, LLC	100.00%	0		24	
25	V	17 Administrative		Petersen Health Care V, LLC	100.00%	0		25	
26	V	19 Professional Services		Petersen Health Care V, LLC	100.00%	2,794	2,794	26	
27	V	20 Dues, Fees, Subs & Promotions		Petersen Health Care V, LLC	100.00%	110	110	27	
28	V	21 Clerical and General Office		Petersen Health Care V, LLC	100.00%	2,947	2,947	28	
29	V	23 Inservice Training & Education		Petersen Health Care V, LLC	100.00%	0		29	
30	V	24 Travel and Seminar		Petersen Health Care V, LLC	100.00%	0		30	
31	V	25 Other Admin. Staff Transport.		Petersen Health Care V, LLC	100.00%	0		31	
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care V, LLC	100.00%	0		32	
33	V	27 Mgmt. Allocation of Benefits		Petersen Health Care V, LLC	100.00%	0		33	
34	V	30 Depreciation		Petersen Health Care V, LLC	100.00%	0		34	
35	V	32 Interest		Petersen Health Care V, LLC	100.00%	8,054	8,054	35	
36	V	33 Real Estate Taxes		Petersen Health Care V, LLC	100.00%	0		36	
37	V	34 Rent-Facility and Grounds		Petersen Health Care V, LLC	100.00%	0		37	
38	V	35 Rent-Equipment & Vehicles		Petersen Health Care V, LLC	100.00%	0		38	
39	Total		\$			\$ 13,905	\$ *	13,905	39

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

Facility Name & ID Number Polo Rehabilitation & Health Care Center # 0049163 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	157,056	0.71	1.18	Salary	\$ 2,057	L17, C7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 2,057		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 Polo Rehabilitation & Health Care Center # 0049163 Report Period Beginning: 1/1/2009 Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,493,044	75	\$ 261,102	\$ 259,584	18,089	\$ 3,163	1
2	2	Food	Resident Days	1,493,044	75	5,864	0	18,089	71	2
3	3	Housekeeping	Resident Days	1,493,044	75	2,458	0	18,089	30	3
4	4	Laundry	Resident Days	1,493,044	75	0	0	18,089	0	4
5	5	Utilities	Resident Days	1,493,044	75	25,776	0	18,089	312	5
6	6	Maintenance	Resident Days	1,493,044	75	126,463	107,810	18,089	1,532	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	47,148	0	18,089	571	7
8	10	Nursing and Medical Records	Resident Days	1,493,044	75	158,020	151,697	18,089	1,914	8
9	10A	Therapy	Resident Days	1,493,044	75	0	0	18,089	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	19,462	0	18,089	236	10
11	17	Administrative	Resident Days	1,493,044	75	3,315,953	3,315,953	18,089	52,882	11
12	19	Professional Services	Resident Days	1,493,044	75	366,089	0	18,089	4,435	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,493,044	75	102,022	0	18,089	1,236	13
14	21	Clerical and General Office	Resident Days	1,493,044	75	2,662,394	2,253,243	18,089	32,256	14
15	23	Inservice Training & Education	Resident Days	1,493,044	75	27,176	0	18,089	329	15
16	24	Travel and Seminar	Resident Days	1,493,044	75	8,381	0	18,089	102	16
17	25	Other Admin. Staff Transport.	Resident Days	1,493,044	75	131,200	0	18,089	1,590	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,493,044	75	54,425	0	18,089	659	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	714,650	0	18,089	8,658	19
20	30	Depreciation	Resident Days	1,493,044	75	215,197	0	18,089	2,607	20
21	32	Interest	Resident Days	1,493,044	75	330,981	0	18,089	4,010	21
22	33	Real Estate Taxes	Resident Days	1,493,044	75	33,065	0	18,089	401	22
23	34	Rent-Facility and Grounds	Resident Days	1,493,044	75	0	0	18,089	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,493,044	75	31,635	0	18,089	383	24
25	TOTALS					\$ 8,639,461	\$ 6,088,287		\$ 117,377	25

Facility Name & ID Number Polo Rehabilitation & Health Care Center

0049163

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 V, 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	58,530	2	\$	\$	18,089	\$	1
2	2	Food	Resident Days	58,530	2			18,089		2
3	3	Housekeeping	Resident Days	58,530	2			18,089		3
4	4	Laundry	Resident Days	58,530	2			18,089		4
5	5	Utilities	Resident Days	58,530	2			18,089		5
6	6	Maintenance	Resident Days	58,530	2			18,089		6
7	7	Mgmt. Allocation of Benefits	Resident Days	58,530	2			18,089		7
8	10	Nursing and Medical Records	Resident Days	58,530	2			18,089		8
9	10A	Therapy	Resident Days	58,530	2			18,089		9
10	15	Mgmt. Allocation of Benefits	Resident Days	58,530	2			18,089		10
11	17	Administrative	Resident Days	58,530	2			18,089		11
12	19	Professional Services	Resident Days	58,530	2	9,042		18,089	2,794	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	58,530	2	357		18,089	110	13
14	21	Clerical and General Office	Resident Days	58,530	2	9,535		18,089	2,947	14
15	23	Inservice Training & Education	Resident Days	58,530	2			18,089		15
16	24	Travel and Seminar	Resident Days	58,530	2			18,089		16
17	25	Other Admin. Staff Transport.	Resident Days	58,530	2			18,089		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	58,530	2			18,089		18
19	27	Mgmt. Allocation of Benefits	Resident Days	58,530	2			18,089		19
20	30	Depreciation	Resident Days	58,530	2			18,089		20
21	32	Interest	Resident Days	58,530	2	26,061		18,089	8,054	21
22	33	Real Estate Taxes	Resident Days	58,530	2			18,089		22
23	34	Rent-Facility and Grounds	Resident Days	58,530	2			18,089		23
24	35	Rent-Equipment & Vehicles	Resident Days	58,530	2			18,089		24
25	TOTALS					\$ 44,995	\$		\$ 13,905	25

Facility Name & ID Number

Polo Rehabilitation & Health Care Center

0049163

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	The Private Bank		X	Mortgage	Varies	4/15/08	\$ 1,136,000	\$ 1,106,498	4/15/13	0.0404	\$ 67,959	1								
2												2								
3							Interest Income Offset				(2,204)	3								
4							Home Office Allocation-PHC				4,010	4								
5							Home Office Allocation-PHC V				8,054	5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related						\$ 1,136,000	\$ 1,106,498			\$ 77,819	9								
B. Non-Facility Related*																				
10							Amortization of Loan Costs				4,412	10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$ 4,412	14								
15	TOTALS (line 9+line14)						\$ 1,136,000	\$ 1,106,498			\$ 82,231	15								

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

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

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

Facility Name & ID Number Polo Rehabilitation & Health Care Center

0049163

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,456 B. General Construction Type: Exterior Brick & Block Frame Wood Number of Stories 1

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

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

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

N/A

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>160,032</u>	<u>2008</u>	<u>\$ 156,372</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	160,032		\$ 156,372	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	81	2008	1972	\$ 1,151,846	\$	39	\$ 29,534	\$ 29,534	\$ 44,301
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				46,074			(46,074)	
29	Building Improvement Booked								
30									
31									
32	2009-Home Office Allocation-Land Improvements			595			37	37	
33	2009-Home Office Allocation-Building Improvements			8,893			213	213	
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)	\$	\$		\$	\$	\$	70
		1,161,334	46,074		29,784	(16,290)	44,301	

**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	\$ 255,501	\$ 36,500	\$ 25,550	\$ (10,950)	10 yrs.	\$ 38,325	71
72	Current Year Purchases	3,526	210	176	(34)	10 yrs.	176	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			2,607	2,607			74
75	TOTALS	\$ 259,027	\$ 36,710	\$ 28,333	\$ (8,377)		\$ 38,501	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)	\$ 1,576,733	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 82,784	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 58,117	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (24,667)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 82,802	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: \$ 12,947 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			N/A		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.

Polo Rehab & Health Care Center

0028852

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	\$	10,149
Dishwasher	\$	137
Copier		2,278
Home Office Allocation		383
		<u>12,947</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	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10A(1,3)	28	hrs	\$ 343	3,618	\$ 54,265	\$	3,646	\$ 54,608	1
2	Licensed Speech and Language Development Therapist	10A(3)		hrs		93	1,393		93	1,393	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)		hrs		9,419	141,289	7	9,419	141,296	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				52,802		52,802	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				\$ 343	13,130	\$ 196,947	\$ 52,809	13,158	\$ 250,099	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 **Polo Rehabilitation & Health Care Center**# **0049163**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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 612,580	\$ 612,580	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>N/A</u>)	312,982	312,982	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	41,075	41,075	6
7	Other Prepaid Expenses	8,974	8,974	7
8	Accounts Receivable (owners or related parties)	11,884	11,884	8
9	Other(specify): <u>Employee Education Loans</u>	399	399	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 987,894	\$ 987,894	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	156,372	156,372	13
14	Buildings, at Historical Cost	1,151,846	1,160,739	14
15	Leasehold Improvements, at Historical Cost		595	15
16	Equipment, at Historical Cost	259,027	259,027	16
17	Accumulated Depreciation (book methods)	(158,477)	(82,802)	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 (spe <u>Loan Costs</u>)	14,338	14,338	22
23	Other(specify): <u>A/R-Prior Owner</u>	15,312	15,312	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,438,418	\$ 1,523,581	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,426,312	\$ 2,511,475	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 328,053	\$ 328,053	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	77,813	77,813	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,860	2,860	31
32	Accrued Real Estate Taxes(Sch.IX-B)	35,000	35,000	32
33	Accrued Interest Payable	1,984	1,984	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	76,173	76,173	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 521,883	\$ 521,883	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,106,498	1,106,498	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)	\$ 1,106,498	\$ 1,106,498	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,628,381	\$ 1,628,381	46
47	TOTAL EQUITY(page 18, line 24)	\$ 797,931	\$ 883,094	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,426,312	\$ 2,511,475	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 426,633	1
2	Restatements (describe):		2
3	Rounding	1	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 426,634	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	371,297	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)	\$ 371,297	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)	\$ 797,931	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Polo Rehabilitation & Health Care Center

0049163

Report Period Beginning: 1/1/2009

Ending: 12/31/2009

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,474,691	1
2	Discounts and Allowances for all Levels	75,444	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,550,135	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	308,437	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 308,437	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	9,365	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	82,350	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	6,483	20
21	Other Medical Services	2,500	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 100,698	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,204	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,204	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Revenue</u>	2,910	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,910	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,964,384	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	552,201	31
32	Health Care	1,168,470	32
33	General Administration	452,340	33
B. Capital Expense			
34	Ownership	204,801	34
C. Ancillary Expense			
35	Special Cost Centers	170,927	35
36	Provider Participation Fee	44,348	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,593,087	40
41	Income before Income Taxes (line 30 minus line 40)**	371,297	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 371,297	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 **Polo Rehabilitation & Health Care Center**

0049163

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,063	2,093	\$ 60,188	\$ 28.76	1
2	Assistant Director of Nursing	4,160	4,176	118,175	28.30	2
3	Registered Nurses	3,780	3,913	98,661	25.21	3
4	Licensed Practical Nurses	9,298	9,734	205,282	21.09	4
5	CNAs & Orderlies	31,875	33,039	335,965	10.17	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	28	28	343	12.25	8
9	Activity Director	2,079	2,142	23,193	10.83	9
10	Activity Assistants	2,011	2,011	16,371	8.14	10
11	Social Service Workers	2082	2,257	29,943	13.27	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	41,352	19.88	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,228	11,855	107,548	9.07	15
16	Dishwashers					16
17	Maintenance Workers	1,988	2,156	44,086	20.45	17
18	Housekeepers	9,693	9,779	86,625	8.86	18
19	Laundry	2,494	2,512	21,728	8.65	19
20	Administrator	2,080	2,080	67,700	32.55	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,946	2,042	22,847	11.19	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	259	284	2,928	10.31	31
32	Other Health C: Transportation	1,488	1,625	16,841	10.36	32
33	Other(specify) Marketing	2,080	2,080	25,611	12.31	33
34	TOTAL (lines 1 - 33)	92,712	95,886	\$ 1,325,387 *	\$ 13.82	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 11,300	9(3)	36
37	Medical Records Consultant	Monthly 360	10(3)	37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 1,200	10(3)	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 12,860		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	209 \$ 5,972	10(3)	50
51	Licensed Practical Nurses			51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)	209 \$ 5,972		53

Polo Rehabilitation & Health Care Center

0049163

Period Beginning 1/1/2009

Period End 12/31/2009

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		5,406

Home Office Allocation

Heyl, Royster, Voelker & Allen	Legal	28
GoffWilson, P.A.	Legal	40
Jackson Lewis	Legal	318
Peter Gartelos	Legal	31
Misc.	Legal	27
Ginoli & Company	Accountants	3,500
Miscellaneous Vendors	Computer Services	29
Emdeon Business Services	Computer Services	13
Advanced Answers on Demand	Computer Services	1,704
Access 2 Go	Computer Services	164
Ivans	Computer Services	19
Kemper Technology	Computer Services	463
VisionShare	Computer Services	144
MediFax	Computer Services	59
LogmeIn	Computer Services	25
Charter Communications	Computer Services	1
Simple LTC	Computer Services	393
Miscellaneous Vendors	Miscellaneous	271
Total (agree to Schedule V, line 19, column 8)		<u>12,635</u>

Facility Name & ID Number Polo Rehabilitation & Health Care Center# 0049163Report 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. \$ 4,462 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. \$ 44,348
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. \$ 9,365
- (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.