

Facility Name & ID Number Sullivan Rehab & Health Care Center

0046425 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	<u>123</u>	Skilled (SNF)	<u>123</u>	<u>44,895</u>	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	<u>123</u>	TOTALS	<u>123</u>	<u>44,895</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>14,049</u>	<u>7,240</u>	<u>3,603</u>	<u>24,892</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>14,049</u>	<u>7,240</u>	<u>3,603</u>	<u>24,892</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 55.44%

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)

Meals on Wheels

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 9/3/03

J. Was the facility purchased or leased after January 1, 1978?

YES Date 9/3/03 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 123 and days of care provided 3,329

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

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	144,639	15,468		160,107		160,107	4,353	164,460		1
2	Food Purchase		143,151		143,151		143,151	(6,640)	136,511		2
3	Housekeeping	95,372	29,935		125,307		125,307	41	125,348		3
4	Laundry	25,002	16,317		41,319		41,319		41,319		4
5	Heat and Other Utilities			142,736	142,736		142,736	430	143,166		5
6	Maintenance	22,946	4,450	13,932	41,328		41,328	2,154	43,482		6
7	Other (specify):* Home Off. Ben. All.							786	786		7
8	TOTAL General Services	287,959	209,321	156,668	653,948		653,948	1,124	655,072		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	1,031,519	86,393	7,343	1,125,255		1,125,255	2,487	1,127,742		10
10a	Therapy	24,307	382	267,666	292,355		292,355		292,355		10a
11	Activities	25,660	796	(178)	26,278		26,278		26,278		11
12	Social Services	31,930			31,930		31,930		31,930		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.							325	325		15
16	TOTAL Health Care and Programs	1,113,416	87,571	286,831	1,487,818		1,487,818	2,812	1,490,630		16
	C. General Administration										
17	Administrative	12,500		247,000	259,500		259,500	(199,170)	60,330		17
18	Directors Fees										18
19	Professional Services			43,837	43,837		43,837	16,395	60,232		19
20	Dues, Fees, Subscriptions & Promotions			6,359	6,359		6,359	2,582	8,941		20
21	Clerical & General Office Expenses	24,348	8,425	9,527	42,300		42,300	52,097	94,397		21
22	Employee Benefits & Payroll Taxes			200,511	200,511		200,511	6,389	206,900		22
23	Inservice Training & Education							635	635		23
24	Travel and Seminar							140	140		24
25	Other Admin. Staff Transportation			5,646	5,646		5,646	5,391	11,037		25
26	Insurance-Prop.Liab.Malpractice			553,280	553,280		553,280	907	554,187		26
27	Other (specify):* Home Off. Ben. All.							11,915	11,915		27
28	TOTAL General Administration	36,848	8,425	1,066,160	1,111,433		1,111,433	(102,719)	1,008,714		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,438,223	305,317	1,509,659	3,253,199		3,253,199	(98,783)	3,154,416		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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			139,346	139,346		139,346	22,090	161,436			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			213,237	213,237		213,237	24,897	238,134			32
33	Real Estate Taxes			41,171	41,171		41,171	551	41,722			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			9,736	9,736		9,736	529	10,265			35
36	Other (specify):*											36
37	TOTAL Ownership			403,490	403,490		403,490	48,067	451,557			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		128,603		128,603		128,603		128,603			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			67,343	67,343		67,343		67,343			42
43	Other (specify):* Non-allowable Cost		489	122,460	122,949		122,949	(122,949)				43
44	TOTAL Special Cost Centers		129,092	189,803	318,895		318,895	(122,949)	195,946			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,438,223	434,409	2,102,952	3,975,584		3,975,584	(173,665)	3,801,919			45

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

Facility Name & ID Number Sullivan Rehab & Health Care Center

0046425

Report Period Beginning: 1/1/2009

Ending: 12/31/2009

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	(6,738)	2		4
5	Telephone, TV & Radio in Resident Rooms	(9,304)	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	(3,166)	30		9
10	Interest and Other Investment Income	(2,093)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(355)	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	(26,997)	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	(68,667)	43		24
25	Fund Raising, Advertising and Promotional	(3,465)	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	(15,395)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (136,180)		\$	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)	(37,485)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (37,485)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (173,665)		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

Sullivan Rehab & Health Care Center

ID# 0046425

Report Period Beginning: 1/1/2009

Ending: 12/31/2009

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Labs-Part A	\$ (6,330)	43	1
2	X-Rays-Part A	(3,808)	43	2
3	Resident Flowers	(1,302)	43	3
4	Disallowed Special Events	(1,701)	43	4
5	Offset Miscellaneous Office Supplies Revenue	(229)	21	5
6	Pet Expense	(1,020)	43	6
7	Offset Miscellaneous Nursing Supplies Revenue	(148)	10	7
8	Offset of Medicare Interest Paid on Withholding	(482)	32	8
9	Offset Chamber of Commerce Dues	(375)	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		(15,395)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sullivan Rehab & Health Care Center# 0046425

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	4,353	0	0	0	0	0	0	0	0	0	4,353	1
2	Food Purchase	(6,738)	98	0	0	0	0	0	0	0	0	0	(6,640)	2
3	Housekeeping	0	41	0	0	0	0	0	0	0	0	0	41	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	430	0	0	0	0	0	0	0	0	0	430	5
6	Maintenance	0	2,108	0	46	0	0	0	0	0	0	0	2,154	6
7	Other (specify):*	0	786	0	0	0	0	0	0	0	0	0	786	7
8	TOTAL General Services	(6,738)	7,816	0	46	0	1,124	8						
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(148)	2,635	0	0	0	0	0	0	0	0	0	2,487	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	325	0	0	0	0	0	0	0	0	0	325	15
16	TOTAL Health Care and Programs	(148)	2,960	0	0	0	0	0	0	0	0	0	2,812	16
	C. General Administration													
17	Administrative	0	(199,170)	0	0	0	0	0	0	0	0	0	(199,170)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	6,103	0	10,292	0	0	0	0	0	0	0	16,395	19
20	Fees, Subscriptions & Promotions	(375)	0	1,701	1,256	0	0	0	0	0	0	0	2,582	20
21	Clerical & General Office Expenses	(229)	0	44,387	7,939	0	0	0	0	0	0	0	52,097	21
22	Employee Benefits & Payroll Taxes	0	0	0	6,389	0	0	0	0	0	0	0	6,389	22
23	Inservice Training & Education	0	0	453	182	0	0	0	0	0	0	0	635	23
24	Travel and Seminar	0	0	140	0	0	0	0	0	0	0	0	140	24
25	Other Admin. Staff Transportation	0	0	2,187	3,204	0	0	0	0	0	0	0	5,391	25
26	Insurance-Prop.Liab.Malpractice	0	0	907	0	0	0	0	0	0	0	0	907	26
27	Other (specify):*	0	0	11,915	0	0	0	0	0	0	0	0	11,915	27
28	TOTAL General Administration	(604)	(193,067)	61,690	29,262	0	(102,719)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(7,490)	(182,291)	61,690	29,308	0	(98,783)	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sullivan Rehab & Health Care Center# 0046425

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(3,166)	0	3,588	21,668	0	0	0	0	0	0	0	22,090	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,575)	0	5,518	21,954	0	0	0	0	0	0	0	24,897	32
33	Real Estate Taxes	0	0	551	0	0	0	0	0	0	0	0	551	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	527	2	0	0	0	0	0	0	0	529	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(5,741)	0	10,184	43,624	0	48,067	37						
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(122,949)	0	0	0	0	0	0	0	0	0	0	(122,949)	43
44	TOTAL Special Cost Centers	(122,949)	0	0	0	0	0	0	0	0	0	0	(122,949)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(136,180)	(182,291)	71,874	72,932	0	0	0	0	0	0	0	(173,665)	45

VII. RELATED PARTIES

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

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

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 4,353	\$ 4,353	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	98	98	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	41	41	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	430	430	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	2,108	2,108	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	786	786	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	2,635	2,635	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%	325	325	10
11	V	17 Administrative	247,000	Petersen Health Care, Inc.	100.00%	47,830	(199,170)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	6,103	6,103	12
13	V							13
14	Total		\$ 247,000			\$ 64,709	\$ * (182,291)	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%	\$ 1,701	\$	1,701	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	44,387		44,387	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	453		453	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	140		140	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	2,187		2,187	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	907		907	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	11,915		11,915	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	3,588		3,588	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	5,518		5,518	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	551		551	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%	527		527	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		\$			\$ 71,874	\$ *	71,874	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 II, Inc.	100.00%	\$ 0	\$	15	
16	V	2 Food		Petersen Health Care II, Inc.	100.00%	0		16	
17	V	3 Housekeeping		Petersen Health Care II, Inc.	100.00%	0		17	
18	V	4 Laundry		Petersen Health Care II, Inc.	100.00%	0		18	
19	V	5 Utilities		Petersen Health Care II, Inc.	100.00%	0		19	
20	V	6 Maintenance		Petersen Health Care II, Inc.	100.00%	46	46	20	
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	100.00%	0		21	
22	V	10 Nursing and Medical Records		Petersen Health Care II, Inc.	100.00%	0		22	
23	V	15 Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	100.00%	0		23	
24	V	17 Administrative		Petersen Health Care II, Inc.	100.00%	0		24	
25	V	19 Professional Services		Petersen Health Care II, Inc.	100.00%	10,292	10,292	25	
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Care II, Inc.	100.00%	1,256	1,256	26	
27	V	21 Clerical and General Office		Petersen Health Care II, Inc.	100.00%	7,939	7,939	27	
28	V	22 Employee Benefits & Payroll		Petersen Health Care II, Inc.	100.00%	6,389	6,389	28	
29	V	23 Inservice Training & Education		Petersen Health Care II, Inc.	100.00%	182	182	29	
30	V	24 Travel and Seminar		Petersen Health Care II, Inc.	100.00%	0		30	
31	V	25 Other Admin. Staff Transport.		Petersen Health Care II, Inc.	100.00%	3,204	3,204	31	
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care II, Inc.	100.00%	0		32	
33	V	27 Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	100.00%	0		33	
34	V	30 Depreciation		Petersen Health Care II, Inc.	100.00%	21,668	21,668	34	
35	V	32 Interest		Petersen Health Care II, Inc.	100.00%	21,954	21,954	35	
36	V	33 Real Estate Taxes		Petersen Health Care II, Inc.	100.00%	0		36	
37	V	34 Rent-Facility and Grounds		Petersen Health Care II, Inc.	100.00%	0		37	
38	V	35 Rent-Equipment & Vehicles		Petersen Health Care II, Inc.	100.00%	2	2	38	
39	Total		\$			\$ 72,932	\$ *	72,932	39

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

Facility Name & ID Number Sullivan Rehab & Health Care Center # 0046425 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Petersen	President	Administrative	100.00	156,283	0.97	1.62	Salary	\$ 2,830	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	\$ 2,830		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 Sullivan Rehab & Health Care Center

0046425

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	24,892	\$ 4,353	1
2	2	Food	Resident Days	1,493,044	75	5,864	0	24,892	98	2
3	3	Housekeeping	Resident Days	1,493,044	75	2,458	0	24,892	41	3
4	4	Laundry	Resident Days	1,493,044	75	0	0	24,892	0	4
5	5	Utilities	Resident Days	1,493,044	75	25,776	0	24,892	430	5
6	6	Maintenance	Resident Days	1,493,044	75	126,463	107,810	24,892	2,108	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	47,148	0	24,892	786	7
8	10	Nursing and Medical Records	Resident Days	1,493,044	75	158,020	151,697	24,892	2,635	8
9	10A	Therapy	Resident Days	1,493,044	75	0	0	24,892	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	19,462	0	24,892	325	10
11	17	Administrative	Resident Days	1,493,044	75	3,315,953	3,315,953	24,892	47,830	11
12	19	Professional Services	Resident Days	1,493,044	75	366,089	0	24,892	6,103	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,493,044	75	102,022	0	24,892	1,701	13
14	21	Clerical and General Office	Resident Days	1,493,044	75	2,662,394	2,253,243	24,892	44,387	14
15	23	Inservice Training & Education	Resident Days	1,493,044	75	27,176	0	24,892	453	15
16	24	Travel and Seminar	Resident Days	1,493,044	75	8,381	0	24,892	140	16
17	25	Other Admin. Staff Transport.	Resident Days	1,493,044	75	131,200	0	24,892	2,187	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,493,044	75	54,425	0	24,892	907	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	714,650	0	24,892	11,915	19
20	30	Depreciation	Resident Days	1,493,044	75	215,197	0	24,892	3,588	20
21	32	Interest	Resident Days	1,493,044	75	330,981	0	24,892	5,518	21
22	33	Real Estate Taxes	Resident Days	1,493,044	75	33,065	0	24,892	551	22
23	34	Rent-Facility and Grounds	Resident Days	1,493,044	75	0	0	24,892	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,493,044	75	31,635	0	24,892	527	24
25	TOTALS					\$ 8,639,461	\$ 6,088,287		\$ 136,583	25

Facility Name & ID Number Sullivan Rehab & Health Care Center

0046425

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 II, 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	336,837	13		24,892		1
2	2	Food	Resident Days	336,837	13		24,892		2
3	3	Housekeeping	Resident Days	336,837	13		24,892		3
4	4	Laundry	Resident Days	336,837	13		24,892		4
5	5	Utilities	Resident Days	336,837	13		24,892		5
6	6	Maintenance	Resident Days	336,837	13	628	24,892	46	6
7	7	Mgmt. Allocation of Benefits	Resident Days	336,837	13		24,892		7
8	10	Nursing and Medical Records	Resident Days	336,837	13		24,892		8
9	15	Mgmt. Allocation of Benefits	Resident Days	336,837	13		24,892		9
10	17	Administrative	Resident Days	336,837	13		24,892		10
11	19	Professional Services	Resident Days	336,837	13	139,269	24,892	10,292	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	336,837	13	17,001	24,892	1,256	12
13	21	Clerical and General Office	Resident Days	336,837	13	107,426	24,892	7,939	13
14	22	Employee Benefits & Payroll	Resident Days	336,837	13	86,458	24,892	6,389	14
15	23	Inservice Training & Education	Resident Days	336,837	13	2,464	24,892	182	15
16	24	Travel and Seminar	Resident Days	336,837	13		24,892		16
17	25	Other Admin. Staff Transport.	Resident Days	336,837	13	43,354	24,892	3,204	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	336,837	13		24,892		18
19	27	Mgmt. Allocation of Benefits	Resident Days	336,837	13		24,892		19
20	30	Depreciation	Resident Days	336,837	13	293,215	24,892	21,668	20
21	32	Interest	Resident Days	336,837	13	297,084	24,892	21,954	21
22	33	Real Estate Taxes	Resident Days	336,837	13		24,892		22
23	34	Rent-Facility and Grounds	Resident Days	336,837	13		24,892		23
24	35	Rent-Equipment & Vehicles	Resident Days	336,837	13	26	24,892	2	24
25	TOTALS					\$ 986,925	\$	\$ 72,932	25

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	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					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	U.S. Bank		X	Mortgage	\$40,714+ int.	12/10/04	\$ 3,420,000	\$ 2,959,230	12/10/11	0.0699	\$ 212,755	1				
2												2				
3							Interest Income Offset				(2,093)	3				
4							Home Office Allocation-PHC				5,518	4				
5							Home Office Allocation-PHC II				21,954	5				
	Working Capital															
6												6				
7												7				
8												8				
9	TOTAL Facility Related						\$ 3,420,000	\$ 2,959,230			\$ 238,134	9				
	B. Non-Facility Related*															
10							Interest Paid on Medicare Withholding				482	10				
11							Interest Offset on Medicare Withholding Interest Paid				(482)	11				
12												12				
13												13				
14	TOTAL Non-Facility Related						\$	\$			\$	14				
15	TOTALS (line 9+line14)						\$ 3,420,000	\$ 2,959,230			\$ 238,134	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.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill

1. Real Estate Tax accrual used on 2008 report.		\$	43,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2008	\$	41,471	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(1,529)	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	42,700	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	551	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	41,722	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2004	42,434	8
	2005	43,662	9
	2006	43,102	10
	2007	41,554	11
	2008	41,471	12

Accrual based on prior year tax bill.

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2008	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u>41,470.62</u>	\$ <u>41,470.62</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment tax bill.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,000 B. General Construction Type: Exterior Brick & Block Frame Concrete Number of Stories 1

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

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

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

N/A

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>339,095</u>	<u>2003</u>	<u>\$ 100,001</u>	1
2					2
3	TOTALS	339,095		\$ 100,001	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	123	2003	1975	\$ 1,560,545	\$	39	\$ 40,014	\$ 40,014	\$ 253,422	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Carpeting		2004	4,808		25	192	192	1,008	9
10	Fire Alarms		2004	1,524		25	61	61	295	10
11	Doors		2004	3,067		5	359	359	3,067	11
12	Smoke Alarms		2004	1,227		7	175	175	864	12
13	Land Improvements		2006	7,262		15	484	484	1,694	13
14	New Roof		2006	28,308		25	1,132	1,132	3,962	14
15	Kitchen Remodel		2006	22,241		25	890	890	3,115	15
16	Landscaping		2006	2,434		15	162	162	567	16
17	Sidewalks		2007	1,785		15	120	120	300	17
18	Sprinkler System		2008	14,839		25	594	594	891	18
19	Back Flow		2009	5,470		7	391	391	391	19
20	Water Heater		2009	2,983		5	298	298	298	20
21										21
22										22
23										23
24										24
25										25
26										26
27	Land Improvements Booked				765			(765)		27
28	Building Booked				40,014			(40,014)		28
29	Building Improvement Booked				6,047			(6,047)		29
30										30
31										31
32	2009-Home Office Allocation-Land Improvements			819			51	51		32
33	2009-Home Office Allocation-Building Improvements			12,237			293	293		33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,669,549	\$ 46,826		\$ 45,216	\$ (1,610)	\$ 269,874	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	\$ 647,746	\$ 92,028	\$ 91,136	\$ (892)	10 yrs.	\$ 494,987	71
72	Current Year Purchases	3,442	492	172	(320)	10 yrs.	172	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			24,912	24,912			74
75	TOTALS	\$ 651,188	\$ 92,520	\$ 116,220	\$ 23,700		\$ 495,159	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	Facility	2003 Ford	2003	\$ 31,116	\$		\$		\$ 31,116	76
77										77
78										78
79										79
80	TOTALS			\$ 31,116	\$	\$	\$		\$ 31,116	80

E. Summary of Care-Related Assets

	1	2		
	Reference	Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,451,854	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 139,346	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 161,436	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 22,090	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 796,149	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

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 \$ _____

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: \$ 10,265 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

* 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.

Sullivan Health Care Center

0046425

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	\$ 6,801
Dishwasher	-
Copier	2,935
Home Office Allocation	529
	<u>10,265</u>

Facility Name & ID Number Sullivan Rehab & Health Care Center # 0046425 Report Period Beginning: 1/1/2009 Ending: 12/31/2009
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>
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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 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$		\$ 114,346	\$		\$ 114,346	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs			34,499			34,499	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	1935 hrs	24,307		118,821	382	1,935	143,510	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				128,603		128,603	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			\$ 24,307		\$ 267,666	\$ 128,985	1,935	\$ 420,958	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 Sullivan Rehab & Health Care Center

0046425

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	\$ 3,672,531	\$ 3,672,531	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>N/A</u>)	507,208	507,208	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	62,374	62,374	6
7	Other Prepaid Expenses	13,122	13,122	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Employee Education Loans</u>	4,328	4,328	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,259,563	\$ 4,259,563	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	111,481	100,001	13
14	Buildings, at Historical Cost	1,560,545	1,572,782	14
15	Leasehold Improvements, at Historical Cost	80,172	96,767	15
16	Equipment, at Historical Cost	686,600	682,304	16
17	Accumulated Depreciation (book methods)	(868,589)	(796,149)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>A/R-Prior Owner</u>	2,698	2,698	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,572,907	\$ 1,658,403	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,832,470	\$ 5,917,966	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 473,542	\$ 473,542	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	88,906	88,906	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,944	1,944	31
32	Accrued Real Estate Taxes(Sch.IX-B)	42,700	42,700	32
33	Accrued Interest Payable	18,636	18,636	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	73,397	73,397	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 699,125	\$ 699,125	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,959,230	2,959,230	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,959,230	\$ 2,959,230	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,658,355	\$ 3,658,355	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,174,115	\$ 2,259,611	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,832,470	\$ 5,917,966	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,392,996	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,392,996	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(218,881)	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)	\$ (218,881)	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)	\$ 2,174,115	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Sullivan Rehab & Health Care Center# 0046425Report Period Beginning: 1/1/2009Ending: 12/31/2009

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,029,282	1
2	Discounts and Allowances for all Levels	(57,047)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,972,235	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	486,348	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 486,348	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	6,738	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	274,095	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	8,991	20
21	Other Medical Services	5,826	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 295,650	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,093	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,093	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	377	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 377	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,756,703	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	653,948	31
32	Health Care	1,487,818	32
33	General Administration	1,111,433	33
B. Capital Expense			
34	Ownership	403,490	34
C. Ancillary Expense			
35	Special Cost Centers	251,552	35
36	Provider Participation Fee	67,343	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,975,584	40
41	Income before Income Taxes (line 30 minus line 40)**	(218,881)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (218,881)	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 Sullivan Rehab & Health Care Center

0046425

Report Period Beginning: 1/1/2009

Ending: 12/31/2009

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4	
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,939	\$ 50,818	\$ 26.21	1
2	Assistant Director of Nursing	2,065	43,921	21.27	2
3	Registered Nurses	11,389	290,600	24.33	3
4	Licensed Practical Nurses	6,004	115,537	18.98	4
5	CNAs & Orderlies	43,324	471,425	10.57	5
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides	1,808	24,307	12.56	8
9	Activity Director	2,065	25,660	11.25	9
10	Activity Assistants				10
11	Social Service Workers	1922	31,930	15.16	11
12	Dietician				12
13	Food Service Supervisor	2,080	34,058	16.37	13
14	Head Cook				14
15	Cook Helpers/Assistants	12,966	110,581	8.15	15
16	Dishwashers				16
17	Maintenance Workers	1,813	22,946	12.22	17
18	Housekeepers	11,186	95,372	8.36	18
19	Laundry	2,640	25,002	8.75	19
20	Administrator	1,993	57,500	29.75	20
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager	2,080	24,348	11.71	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	1,191	13,604	10.18	31
32	Other Health Care(specify)				32
33	Other(specify) <u>Care Plan Coord.</u>	1,936	45,614	21.76	33
34	TOTAL (lines 1 - 33)	108,401	\$ 1,483,223 *	\$ 13.22	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$		35
36	Medical Director	Monthly 12,000	9(3)	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 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)	\$ 13,200		49

C. CONTRACT NURSES

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

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	
Laura Northway	Adminstrator	0	\$ 57,500	Workers' Compensation Insurance	\$ 61,581	IDPH License Fee	\$ 995	
				Unemployment Compensation Insurance	21,999	Advertising: Employee Recruitment	539	
				FICA Taxes	108,601	Health Care Worker Background Check		
				Employee Health Insurance	7,038	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks	268 2,680	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	270	
				Employee Relations	6,596	Miscellaneous Dues & Subscriptions	375	
				Employee Retirement	1,085	IHCA Dues	1,500	
						Home Office Allocation	2,957	
TOTAL (agree to Schedule V, line 17, col. 1)						Less: Public Relations Expense	(375)	
(List each licensed administrator separately.)			\$ 57,500			Non-allowable advertising	()	
						Yellow page advertising	()	
B. Administrative - Other						TOTAL (agree to Sch. V, line 20, col. 8)		
Description			Amount			\$ 8,941		
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 247,000					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 247,000					
(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	\$ 3,045				Out-of-State Travel	\$	
Mediacom	Computer Services	1,205						
LTC Solutions	Computer Services	1,700						
SimpleLTC, Inc.	Computer Services	81	N/A			In-State Travel		
Misc. Vendors	Legal Services	25						
Heyl, Royster, Voelker & Allen	Legal Services	32,893						
Donahue, Brown, Mathewson, Etc.	Legal Services	3,638				Seminar Expense		
MediateOne, Inc.	Legal Services	1,250				Home Office Allocation	140	
						Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL	\$	(agree to Sch. V, line 24, col. 8)		
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 43,837			TOTAL	\$ 140	

* Attach copy of IMRF notifications

**See instructions.

Sullivan Rehab & Health Care Center

0046425

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)		43,837

Home Office Allocation

Heyl, Royster, Voelker & Allen	Legal	39
GoffWilson, P.A.	Legal	55
Jackson Lewis	Legal	432
Peter Gartelos	Legal	42
Misc.	Legal	37
Ginoli & Company	Accountants	2,888
Miscellaneous Vendors	Computer Services	40
Emdeon Business Services	Computer Services	18
Advanced Answers on Demand	Computer Services	2,345
Access 2 Go	Computer Services	225
Ivans	Computer Services	140
Kemper Technology	Computer Services	637
VisionShare	Computer Services	198
MediFax	Computer Services	81
Logmein	Computer Services	35
Charter Communications	Computer Services	2
CDW	Computer Services	356
Simple LTC	Computer Services	541
Polaris Group	Other Professional Services	7,772
Donna Howard & Assoc.	Other Professional Services	133
Miscellaneous Vendors	Miscellaneous	378
Total (agree to Schedule V, line 19, column 8)		<u>60,232</u>

Sullivan Rehab & Health Care Center

0046425

Period Beginning

1/1/2009

Period End

12/31/2009

Schedule 21B

XIX. SUPPORT SCHEDULE

Legal Fees

Facility

Vendor/Payee	Invoice Total	Allocation %	Total
Misc. Vendors	25.00	100%	25
Heyl, Royster, Voelker, & Allen	3,979.33	100%	3,979
Heyl, Royster, Voelker, & Allen	4,534.67	100%	4,535
Heyl, Royster, Voelker, & Allen	2,662.05	100%	2,662
Donohue, Brown, Mathewson & Smyl	3,638.00	100%	3,638
Heyl, Royster, Voelker, & Allen	3,815.42	100%	3,815
Heyl, Royster, Voelker, & Allen	5,717.49	100%	5,717
MediateOne	1,250.00	100%	1,250
Heyl, Royster, Voelker, & Allen	192.50	100%	193
Heyl, Royster, Voelker, & Allen	5,192.53	100%	5,193
Heyl, Royster, Voelker, & Allen	1,768.13	100%	1,768
Heyl, Royster, Voelker, & Allen	4,330.07	100%	4,330
Heyl, Royster, Voelker, & Allen	700.49	100%	700

Home Office Allocation

Heyl, Royster, Voelker, and Allen	2,414.77	1.61%	39
GoffWilson	3,425.00	1.61%	55
Jackson Lewis	27,043.20	1.61%	432
Peter Gartelos	2,612.50	1.61%	42
Miscellaneous Vendors	2,327.62	1.61%	37

Total Legal Fees

38,412

Facility Name & ID Number Sullivan Rehab & Health Care Center

0046425

Report Period Beginning: 1/1/2009

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? 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. \$ 9,651 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. \$ 67,343
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. \$ 6,738
- (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? Yes
Attach invoices and a summary of services for all architect and appraisal fees.