		FOR BHF USE					

LL1

2009
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2009)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0048207

Facility Name: Whispering Oaks

Address: 201 Spring Street (Number) Rosiclare (City) 62982 (Zip Code)

County: Hardin

Telephone Number: (618)285-6974 **Fax #** (618) 289-4860

HFS ID Number: 37-1333487

Date of Initial License for Current Owners: 2/28/2006

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2009 to 12/31/2009 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed) (Date)
	(Type or Print Name) Mark B. Petersen
	(Title) Chief Executive Officer
Paid Preparer	(Signed) (Date)
	(Print Name and Title)
	(Firm Name & Address)
	(Telephone) ( ) Fax # ( )

In the event there are further questions about this report, please contact:
Name: Larry Templin Telephone Number: (309) 691-8113
Email Address:

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Whispering Oaks # 0048207 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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	3,555			3,555	13
14	TOTALS	3,555			3,555	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 60.87%

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 [X] 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 [X]

I. On what date did you start providing long term care at this location?
Date started 2/28/2006

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 2/28/2006 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified 0 and days of care provided 0

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] 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 Whispering Oaks # 0048207 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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	19,177	1,887		21,064		21,064	622	21,686			1
2	Food Purchase		15,739		15,739		15,739	14	15,753			2
3	Housekeeping	16,139	2,364		18,503		18,503	6	18,509			3
4	Laundry		1,967		1,967		1,967		1,967			4
5	Heat and Other Utilities			14,395	14,395		14,395	61	14,456			5
6	Maintenance		2,851	3,813	6,664		6,664	596	7,260			6
7	Other (specify):* Home Off. Ben. All.							112	112			7
8	**TOTAL General Services**	35,316	24,808	18,208	78,332		78,332	1,411	79,743			8
	B. Health Care and Programs											
9	Medical Director			1,000	1,000		1,000		1,000			9
10	Nursing and Medical Records	128,337	6,382	600	135,319		135,319	(683)	134,636			10
10a	Therapy											10a
11	Activities	20,264	364	251	20,879		20,879		20,879			11
12	Social Services		84		84		84		84			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Off. Ben. All.							46	46			15
16	**TOTAL Health Care and Programs**	148,601	6,830	1,851	157,282		157,282	(637)	156,645			16
	C. General Administration											
17	Administrative	7,500		29,100	36,600		36,600	(5,050)	31,550			17
18	Directors Fees											18
19	Professional Services			340	340		340	1,077	1,417			19
20	Dues, Fees, Subscriptions & Promotions			2,765	2,765		2,765	457	3,222			20
21	Clerical & General Office Expenses		657	2,289	2,946		2,946	6,765	9,711			21
22	Employee Benefits & Payroll Taxes			53,006	53,006		53,006		53,006			22
23	Inservice Training & Education			56	56		56	65	121			23
24	Travel and Seminar							20	20			24
25	Other Admin. Staff Transportation			1,004	1,004		1,004	365	1,369			25
26	Insurance-Prop.Liab.Malpractice			5,366	5,366		5,366	130	5,496			26
27	Other (specify):* Home Off. Ben. All.							2,336	2,336			27
28	**TOTAL General Administration**	7,500	657	93,926	102,083		102,083	6,165	108,248			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	191,417	32,295	113,985	337,697		337,697	6,939	344,636			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 Whispering Oaks #0048207 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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			34,964	34,964		34,964	(3,109)	31,855			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			26,403	26,403		26,403	5,078	31,481			32
33	Real Estate Taxes			4,933	4,933		4,933	79	5,012			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			2,498	2,498		2,498	75	2,573			35
36	Other (specify):*											36
37	TOTAL Ownership			68,798	68,798		68,798	2,123	70,921			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			23,910	23,910		23,910		23,910			42
43	Other (specify):* Non-allowable Cost			1,419	1,419		1,419	(1,419)				43
44	TOTAL Special Cost Centers			25,329	25,329		25,329	(1,419)	23,910			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	191,417	32,295	208,112	431,824		431,824	7,643	439,467			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 Whispering Oaks # 0048207 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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(1,093)	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	(3,804)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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				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				24
25	Fund Raising, Advertising and Promotional	(264)	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	(1,157)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (6,318)		$	30

BHF USE ONLY									
48		49		50		51		52	

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 Amount	2 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)	#REF!	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ #REF!		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ #REF!		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 Yes	2 No	3 Amount	4 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

STATE OF ILLINOIS

Whispering Oaks

ID# 0048207

Report Period Beginning: 1/1/2009

Ending: 12/31/2009

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Offset Miscellaneous Office Supplies Revenue	(36)	21	1
2	Resident Flowers	(62)	43	2
3	Offset Miscellaneous Nursing Supplies Revenue	(1,059)	10	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
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26				26
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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**	(1,157)		49

Facility Name & ID Number Whispering Oaks # 0048207 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] 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%	$ 243	$ 243	15
16	V	21	Clerical and General Office		Petersen Health Care, Inc.	100.00%	6,339	6,339	16
17	V	23	Inservice Training and Education		Petersen Health Care, Inc.	100.00%	65	65	17
18	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	20	20	18
19	V	25	Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	312	312	19
20	V	26	Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	130	130	20
21	V	27	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,702	1,702	21
22	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	512	512	22
23	V	32	Interest		Petersen Health Care, Inc.	100.00%	788	788	23
24	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	79	79	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%	75	75	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			$			$ 10,265	$ * 10,265	39

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

Facility Name & ID Number Whispering Oaks # 0048207 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Petersen Health Operations, LLC	100.00%	$ 0	$	15
16	V	2	Food		Petersen Health Operations, LLC	100.00%	0		16
17	V	3	Housekeeping		Petersen Health Operations, LLC	100.00%	0		17
18	V	4	Laundry		Petersen Health Operations, LLC	100.00%	0		18
19	V	5	Utilities		Petersen Health Operations, LLC	100.00%	0		19
20	V	6	Maintenance		Petersen Health Operations, LLC	100.00%	295	295	20
21	V	7	Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	0		21
22	V	10	Nursing and Medical Records		Petersen Health Operations, LLC	100.00%	0		22
23	V	15	Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	0		23
24	V	17	Administrative		Petersen Health Operations, LLC	100.00%	0		24
25	V	19	Professional Services		Petersen Health Operations, LLC	100.00%	205	205	25
26	V	20	Dues, Fees, Subs & Promotions		Petersen Health Operations, LLC	100.00%	214	214	26
27	V	21	Clerical and General Office		Petersen Health Operations, LLC	100.00%	462	462	27
28	V	22	Employee Benefits & Payroll		Petersen Health Operations, LLC	100.00%	0		28
29	V	23	Inservice Training & Education		Petersen Health Operations, LLC	100.00%	0		29
30	V	24	Travel and Seminar		Petersen Health Operations, LLC	100.00%	0		30
31	V	25	Other Admin. Staff Transport.		Petersen Health Operations, LLC	100.00%	53	53	31
32	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Operations, LLC	100.00%	0		32
33	V	27	Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	634	634	33
34	V	30	Depreciation		Petersen Health Operations, LLC	100.00%	183	183	34
35	V	32	Interest		Petersen Health Operations, LLC	100.00%	3,335	3,335	35
36	V	33	Real Estate Taxes		Petersen Health Operations, LLC	100.00%	0		36
37	V	34	Rent-Facility and Grounds		Petersen Health Operations, LLC	100.00%	0		37
38	V	35	Rent-Equipment & Vehicles		Petersen Health Operations, LLC	100.00%	0		38
39	Total			$			$ 5,381	$ * 5,381	39

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

Facility Name & ID Number Whispering Oaks # 0048207 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Petersen Health Network, LLC	100.00%	$	$	15
16	V	2	Food		Petersen Health Network, LLC	100.00%			16
17	V	3	Housekeeping		Petersen Health Network, LLC	100.00%			17
18	V	4	Laundry		Petersen Health Network, LLC	100.00%			18
19	V	5	Utilities		Petersen Health Network, LLC	100.00%			19
20	V	6	Maintenance		Petersen Health Network, LLC	100.00%			20
21	V	7	Mgmt. Allocation of Benefits		Petersen Health Network, LLC	100.00%			21
22	V	10	Nursing and Medical Records		Petersen Health Network, LLC	100.00%			22
23	V	15	Mgmt. Allocation of Benefits		Petersen Health Network, LLC	100.00%			23
24	V	17	Administrative		Petersen Health Network, LLC	100.00%			24
25	V	19	Professional Services		Petersen Health Network, LLC	100.00%			25
26	V	20	Dues, Fees, Subs & Promotions		Petersen Health Network, LLC	100.00%			26
27	V	21	Clerical and General Office		Petersen Health Network, LLC	100.00%			27
28	V	22	Employee Benefits & Payroll		Petersen Health Network, LLC	100.00%			28
29	V	23	Inservice Training & Education		Petersen Health Network, LLC	100.00%			29
30	V	24	Travel and Seminar		Petersen Health Network, LLC	100.00%			30
31	V	25	Other Admin. Staff Transport.		Petersen Health Network, LLC	100.00%			31
32	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Network, LLC	100.00%			32
33	V	27	Mgmt. Allocation of Benefits		Petersen Health Network, LLC	100.00%			33
34	V	30	Depreciation		Petersen Health Network, LLC	100.00%			34
35	V	32	Interest		Petersen Health Network, LLC	100.00%	955	955	35
36	V	33	Real Estate Taxes		Petersen Health Network, LLC	100.00%			36
37	V	34	Rent-Facility and Grounds		Petersen Health Network, LLC	100.00%			37
38	V	35	Rent-Equipment & Vehicles		Petersen Health Network, LLC	100.00%			38
39	Total			$			$ 955	$ * 955	39

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

Facility Name & ID Number Whispering Oaks # 0048207 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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Petersen	President	Administrative	100.00	158,709	0.14	0.23	Salary	$ 404	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	$ 404		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 Whispering Oaks # 0048207 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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	1,493,044	75	$ 261,102	$ 259,584	3,555	$ 622	1
2	2	Food	Resident Days	1,493,044	75	5,864	0	3,555	14	2
3	3	Housekeeping	Resident Days	1,493,044	75	2,458	0	3,555	6	3
4	4	Laundry	Resident Days	1,493,044	75	0	0	3,555	0	4
5	5	Utilities	Resident Days	1,493,044	75	25,776	0	3,555	61	5
6	6	Maintenance	Resident Days	1,493,044	75	126,463	107,810	3,555	301	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	47,148	0	3,555	112	7
8	10	Nursing and Medical Records	Resident Days	1,493,044	75	158,020	151,697	3,555	376	8
9	10A	Therapy	Resident Days	1,493,044	75	0	0	3,555	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	19,462	0	3,555	46	10
11	17	Administrative	Resident Days	1,493,044	75	3,315,953	3,315,953	3,555	24,050	11
12	19	Professional Services	Resident Days	1,493,044	75	366,089	0	3,555	872	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,493,044	75	102,022	0	3,555	243	13
14	21	Clerical and General Office	Resident Days	1,493,044	75	2,662,394	2,253,243	3,555	6,339	14
15	23	Inservice Training & Education	Resident Days	1,493,044	75	27,176	0	3,555	65	15
16	24	Travel and Seminar	Resident Days	1,493,044	75	8,381	0	3,555	20	16
17	25	Other Admin. Staff Transport.	Resident Days	1,493,044	75	131,200	0	3,555	312	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,493,044	75	54,425	0	3,555	130	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	714,650	0	3,555	1,702	19
20	30	Depreciation	Resident Days	1,493,044	75	215,197	0	3,555	512	20
21	32	Interest	Resident Days	1,493,044	75	330,981	0	3,555	788	21
22	33	Real Estate Taxes	Resident Days	1,493,044	75	33,065	0	3,555	79	22
23	34	Rent-Facility and Grounds	Resident Days	1,493,044	75	0	0	3,555	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,493,044	75	31,635	0	3,555	75	24
25	TOTALS					$ 8,639,461	$ 6,088,287		$ 36,725	25

Facility Name & ID Number Whispering Oaks # 0048207 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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	398,596	21	$	$	3,006	$	1
2	2	Food	Resident Days	398,596	21			3,006		2
3	3	Housekeeping	Resident Days	398,596	21			3,006		3
4	4	Laundry	Resident Days	398,596	21			3,006		4
5	5	Utilities	Resident Days	398,596	21			3,006		5
6	6	Maintenance	Resident Days	398,596	21	39,101		3,006	295	6
7	7	Mgmt. Allocation of Benefits	Resident Days	398,596	21			3,006		7
8	10	Nursing and Medical Records	Resident Days	398,596	21			3,006		8
9	12	Social Services	Resident Days	398,596	21			3,006		9
10	17	Administrative	Resident Days	398,596	21			3,006		10
11	19	Professional Services	Resident Days	398,596	21	27,246		3,006	205	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	398,596	21	28,361		3,006	214	12
13	21	Clerical and General Office	Resident Days	398,596	21	61,225		3,006	462	13
14	22	Employee Benefits & Payroll	Resident Days	398,596	21			3,006		14
15	23	Inservice Training & Education	Resident Days	398,596	21			3,006		15
16	24	Travel and Seminar	Resident Days	398,596	21			3,006		16
17	25	Other Admin. Staff Transport.	Resident Days	398,596	21	7,017		3,006	53	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	398,596	21			3,006		18
19	27	Mgmt. Allocation of Benefits	Resident Days	398,596	21	84,022		3,006	634	19
20	30	Depreciation	Resident Days	398,596	21	24,325		3,006	183	20
21	32	Interest	Resident Days	398,596	21	442,158		3,006	3,335	21
22	33	Real Estate Taxes	Resident Days	398,596	21			3,006		22
23	34	Rent-Facility and Grounds	Resident Days	398,596	21			3,006		23
24	35	Rent-Equipment & Vehicles	Resident Days	398,596	21			3,006		24
25	TOTALS					$ 713,455	$		$ 5,381	25

Facility Name & ID Number Whispering Oaks # 0048207 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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	32,882	12	$	$	549	$	1
2	2	Food	Resident Days	32,882	12			549		2
3	3	Housekeeping	Resident Days	32,882	12			549		3
4	4	Laundry	Resident Days	32,882	12			549		4
5	5	Utilities	Resident Days	32,882	12			549		5
6	6	Maintenance	Resident Days	32,882	12			549		6
7	7	Mgmt. Allocation of Benefits	Resident Days	32,882	12			549		7
8	10	Nursing and Medical Records	Resident Days	32,882	12			549		8
9	12	Social Services	Resident Days	32,882	12			549		9
10	17	Administrative	Resident Days	32,882	12			549		10
11	19	Professional Services	Resident Days	32,882	12			549		11
12	20	Dues, Fees, Subs & Promotions	Resident Days	32,882	12			549		12
13	21	Clerical and General Office	Resident Days	32,882	12			549		13
14	22	Employee Benefits & Payroll	Resident Days	32,882	12			549		14
15	23	Inservice Training & Education	Resident Days	32,882	12			549		15
16	24	Travel and Seminar	Resident Days	32,882	12			549		16
17	25	Other Admin. Staff Transport.	Resident Days	32,882	12			549		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	32,882	12			549		18
19	27	Mgmt. Allocation of Benefits	Resident Days	32,882	12			549		19
20	30	Depreciation	Resident Days	32,882	12			549		20
21	32	Interest	Resident Days	32,882	12	57,172		549	955	21
22	33	Real Estate Taxes	Resident Days	32,882	12			549		22
23	34	Rent-Facility and Grounds	Resident Days	32,882	12			549		23
24	35	Rent-Equipment & Vehicles	Resident Days	32,882	12			549		24
25	TOTALS					$ 57,172	$		$ 955	25

Facility Name & ID Number Whispering Oaks # 0048207 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	Associated Bank		X	Mortgage	$5,428.00	01/05/06	$ 600,000	$	Paid	0.0894	$ 20,406	1
2	The Private Bank		X	Mortgage	Varies	11/1/09	413,015	411,937	10/31/09	Varies	2,964	2
3							Home Office Allocation-PHN				955	3
4							Home Office Allocation-PHC				788	4
5							Home Office Allocation-PHO				3,335	5
	Working Capital											
6	Associated Bank		X	Capital	Varies	10/1/08	100,000		Paid	Prime	2,219	6
7												7
8												8
9	TOTAL Facility Related				$5,428.00		$ 1,113,015	$ 411,937			$ 30,667	9
	B. Non-Facility Related*											
10							Amortization Expense				814	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 814	14
15	TOTALS (line 9+line14)						$ 1,113,015	$ 411,937			$ 31,481	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 Whispering Oaks # 0048207 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

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

1. Real Estate Tax accrual used on 2008 report.		$ 4,700	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	$ 4,733	2
3. Under or (over) accrual (line 2 minus line 1).		$ 33	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 4,900	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.	Home Office Allocation	79	
TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 5,012	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
2004			8
2005	3,763		9
2006	4,256		10
2007	4,529		11
2008	4,733		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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2008 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2008 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2008.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2008 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2009 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2008 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Whispering Oaks COUNTY Hardin

FACILITY IDPH LICENSE NUMBER 0048207

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

TELEPHONE (309) 691-8113 FAX #: (309) 691-8113

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2008 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2008.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-82-057-08-000	Long-Term Care Facility	4,732.82	4,732.82
2.				
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 4,732.82	$ 4,732.82

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.

Facility Name & ID Number Whispering Oaks # 0048207 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 3,320 B. General Construction Type: Exterior Vinyl Siding Frame Wood Number of Stories 1

C. Does the Operating Entity? [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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 [X] 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	Facility	10,000	2006	$ 10,000	1
2					2
3	TOTALS	10,000		$ 10,000	3

Facility Name & ID Number Whispering Oaks # 0048207 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16		2006	1994	$ 530,000	$	25	$ 21,200	$ 21,200	$ 74,042	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	A/C Unit			2009	2,985		5	299	299	299	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	Building Booked					21,200			(21,200)		28
29	Building Improvement Booked					299			(299)		29
30											30
31											31
32	2009-Home Office Allocation-Land Improvements				117			7	7		32
33	2009-Home Office Allocation-Building Improvements				1,748			42	42		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

Facility Name & ID Number Whispering Oaks # 0048207 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 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)		$ 534,850	$ 21,499		$ 21,548	$ 49	$ 74,341	70

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

Facility Name & ID Number Whispering Oaks # 0048207 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 68,052	$ 13,465	$ 9,612	$ (3,853)	5-10 yrs.	$ 33,436	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Home Office Allocation			695	695			74
75	TOTALS	$ 68,052	$ 13,465	$ 10,307	$ (3,158)		$ 33,436	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)	$ 612,902	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 34,964	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 31,855	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (3,109)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 107,777	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.

Facility Name & ID Number Whispering Oaks # 0048207 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

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: _____ *

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	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 2,573 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

* 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.

Whispering Oaks
0048207
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	$	2,498
Home Office Allocation		75
		2,573

Facility Name & ID Number Whispering Oaks # 0048207 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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

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.

[ ] YES
[X] NO

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
COMMUNITY COLLEGE [ ]
HOURS PER CNA ____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.

Facility Name & ID Number Whispering Oaks # 0048207 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	N/A	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							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			$		$	$		$	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 Whispering Oaks # 0048207 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	$ 393,365	$ 393,365	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance N/A)	219,797	219,797	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	7,976	7,976	6
7	Other Prepaid Expenses	1,616	1,616	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 622,754	$ 622,754	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	10,000	10,000	13
14	Buildings, at Historical Cost	530,000	531,748	14
15	Leasehold Improvements, at Historical Cost	2,985	3,102	15
16	Equipment, at Historical Cost	68,052	68,052	16
17	Accumulated Depreciation (book methods)	(129,858)	(107,777)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 481,179	$ 505,125	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,103,933	$ 1,127,879	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 14,708	$ 14,708	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	12,732	12,732	30
31	Accrued Taxes Payable (excluding real estate taxes)	281	281	31
32	Accrued Real Estate Taxes(Sch.IX-B)	4,900	4,900	32
33	Accrued Interest Payable	871	871	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	7,613	7,613	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 41,105	$ 41,105	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	411,937	411,937	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)**	$ 411,937	$ 411,937	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 453,042	$ 453,042	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 650,891	$ 674,837	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,103,933	$ 1,127,879	48

*(See instructions.)

Facility Name & ID Number Whispering Oaks # 0048207 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 102,673	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 102,673	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(62,051)	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)**	$ (62,051)	17
	B. Transfers (Itemize):		
18	Transfer of Net Assets	610,269	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 610,269	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 650,891	24 *

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

Facility Name & ID Number Whispering Oaks # 0048207 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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 368,678	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 368,678	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	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		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	1,095	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,095	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 369,773	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	78,332	31
32	Health Care	157,282	32
33	General Administration	102,083	33
	B. Capital Expense		
34	Ownership	68,798	34
	C. Ancillary Expense		
35	Special Cost Centers	1,419	35
36	Provider Participation Fee	23,910	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 431,824	40
41	**Income before Income Taxes (line 30 minus line 40)****	(62,051)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (62,051)	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 Whispering Oaks # 0048207 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
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies	10,600	11,092	87,829	7.92	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,005	2,130	20,264	9.51	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	1,797	1,931	19,177	9.93	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	1,928	2,021	16,139	7.99	18
19	Laundry					19
20	Administrator	1,991	1,991	31,147	15.64	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					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)	4,996	5,106	40,508	7.93	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	23,317	24,271	$ 215,064 *	$ 8.86	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	1,000	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	600	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 1,600		49

C. CONTRACT NURSES

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

Facility Name & ID Number Whispering Oaks # 0048207 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Patricia Brazier	Administrator	0	$ 21,429
Barbara Gibbs	Administrator	0	9,718
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 31,147

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 29,100
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 29,100

C. Professional Services

Vendor/Payee	Type	Amount
Shawnee Communications	Computer Services	$ 300
Hardin Country	Legal Services	40
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 340

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 9,220
Unemployment Compensation Insurance	5,267
FICA Taxes	14,158
Employee Health Insurance	24,161
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	200
TOTAL (agree to Schedule V, line 22, col.8)	$ 53,006

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 995
Advertising: Employee Recruitment	250
Health Care Worker Background Check (Indicate # of checks performed 2)	
Patient Background Checks	20
Miscellaneous Licenses & Permits	0
Miscellaneous Dues & Subscriptions	0
IHCA Dues	1,500
Home Office Allocation	457
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 3,222

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Home Office Allocation	20
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 20

**See instructions.

Whispering Oaks
0048207
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)		340
Home Office Allocation		
Heyl, Royster, Voelker & Allen	Legal	(1)
GoffWilson, P.A.	Legal	8
Jackson Lewis	Legal	62
Peter Gartelos	Legal	6
Misc.	Legal	5
Ginoli & Company	Accountants	340
Miscellaneous Vendors	Computer Services	6
Emdeon Business Services	Computer Services	3
Advanced Answers on Demand	Computer Services	335
Access 2 Go	Computer Services	32
Ivans	Computer Services	16
Kemper Technology	Computer Services	91
VisionShare	Computer Services	28
MediFax	Computer Services	12
Logmeln	Computer Services	5
Charter Communications	Computer Services	-
Simple LTC	Computer Services	77
Miscellaneous Vendors	Miscellaneous	52
Total (agree to Schedule V, line 19, column 8)		1,417

Facility Name & ID Number Whispering Oaks # 0048207 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4	N/A												
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Whispering Oaks # 0048207 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. $ **1,153** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **N/A**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **23,910**
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? **No** Indicate the amount. $ **N/A**

(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 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.