

Facility Name & ID Number White Oaks Rehabilitation & Health Care Center

0047910 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	65	Skilled (SNF)	65	23,725	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	65	TOTALS	65	23,725	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	10,714	3,046	4,794	18,554	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,714	3,046	4,794	18,554	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.20%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 3/01/2006

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

YES Date 3/01/2006 NO

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

YES NO If YES, enter number of beds certified 65 and days of care provided 4,347

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

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

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

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	101,274	12,831		114,105		114,105	3,245	117,350		1
2	Food Purchase		111,704		111,704		111,704	(2,301)	109,403		2
3	Housekeeping	70,187	23,126		93,313		93,313	31	93,344		3
4	Laundry	25,118	9,028		34,146		34,146		34,146		4
5	Heat and Other Utilities			96,423	96,423		96,423	320	96,743		5
6	Maintenance	26,594	5,817	34,801	67,212		67,212	1,607	68,819		6
7	Other (specify):* Home Off. Ben. All.							586	586		7
8	TOTAL General Services	223,173	162,506	131,224	516,903		516,903	3,488	520,391		8
	B. Health Care and Programs										
9	Medical Director			9,000	9,000		9,000		9,000		9
10	Nursing and Medical Records	935,116	77,756	37,763	1,050,635		1,050,635	(915)	1,049,720		10
10a	Therapy	521,930	556	110	522,596		522,596		522,596		10a
11	Activities	15,757	72	3,085	18,914		18,914		18,914		11
12	Social Services	24,202			24,202		24,202		24,202		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.							242	242		15
16	TOTAL Health Care and Programs	1,497,005	78,384	49,958	1,625,347		1,625,347	(673)	1,624,674		16
	C. General Administration										
17	Administrative	15,000		128,000	143,000		143,000	(80,891)	62,109		17
18	Directors Fees										18
19	Professional Services			23,602	23,602		23,602	12,220	35,822		19
20	Dues, Fees, Subscriptions & Promotions			9,062	9,062		9,062	2,054	11,116		20
21	Clerical & General Office Expenses	21,848	5,393	8,695	35,936		35,936	38,613	74,549		21
22	Employee Benefits & Payroll Taxes			215,650	215,650		215,650	4,762	220,412		22
23	Inservice Training & Education							474	474		23
24	Travel and Seminar							104	104		24
25	Other Admin. Staff Transportation			4,963	4,963		4,963	4,018	8,981		25
26	Insurance-Prop.Liab.Malpractice			63,522	63,522		63,522	676	64,198		26
27	Other (specify):* Home Off. Ben. All.							8,881	8,881		27
28	TOTAL General Administration	36,848	5,393	453,494	495,735		495,735	(9,089)	486,646		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,757,026	246,283	634,676	2,637,985		2,637,985	(6,274)	2,631,711		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			151,471	151,471		151,471	(26,954)	124,517			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			137,465	137,465		137,465	13,799	151,264			32
33	Real Estate Taxes			31,522	31,522		31,522	411	31,933			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			10,712	10,712		10,712	394	11,106			35
36	Other (specify):*											36
37	TOTAL Ownership			331,170	331,170		331,170	(12,350)	318,820			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		211,853		211,853		211,853		211,853			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			35,588	35,588		35,588		35,588			42
43	Other (specify):* Non-allowable Cost		49	173,972	174,021		174,021	(174,021)				43
44	TOTAL Special Cost Centers		211,902	209,560	421,462		421,462	(174,021)	247,441			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,757,026	458,185	1,175,406	3,390,617		3,390,617	(192,645)	3,197,972			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 White Oaks Rehabilitation & Health Care Center

0047910

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	(2,374)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(45,779)	30		9
10	Interest and Other Investment Income	(6,678)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(163)	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				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	(141,864)	43		24
25	Fund Raising, Advertising and Promotional	(805)	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	(34,607)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (232,270)		\$	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)	39,625	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 39,625		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (192,645)		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

White Oaks Rehabilitation & Health Care Center

ID# 0047910

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	\$ (17,718)	43	1
2	X-Rays-Part A	(11,030)	43	2
3	Offset Miscellaneous Nursing Supplies Revenue	(2,879)	10	3
4	Offset Miscellaneous Office Supplies Revenue	(389)	21	4
5	Disallowed Special Events	(727)	43	5
6	Resident Flowers	(1,714)	43	6
7	Disallowed Chamber of Commerce Dues	(150)	20	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		(34,607)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number White Oaks Rehabilitation & Health Care Center# 0047910

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	3,245	0	0	0	0	0	0	0	0	0	3,245	1
2	Food Purchase	(2,374)	73	0	0	0	0	0	0	0	0	0	(2,301)	2
3	Housekeeping	0	31	0	0	0	0	0	0	0	0	0	31	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	320	0	0	0	0	0	0	0	0	0	320	5
6	Maintenance	0	1,572	0	35	0	0	0	0	0	0	0	1,607	6
7	Other (specify):*	0	586	0	0	0	0	0	0	0	0	0	586	7
8	TOTAL General Services	(2,374)	5,827	0	35	0	3,488	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	(2,879)	1,964	0	0	0	0	0	0	0	0	0	(915)	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	242	0	0	0	0	0	0	0	0	0	242	15
16	TOTAL Health Care and Programs	(2,879)	2,206	0	0	0	0	0	0	0	0	0	(673)	16
	C. General Administration													
17	Administrative	0	(80,891)	0	0	0	0	0	0	0	0	0	(80,891)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	4,549	0	7,671	0	0	0	0	0	0	0	12,220	19
20	Fees, Subscriptions & Promotions	(150)	0	1,268	936	0	0	0	0	0	0	0	2,054	20
21	Clerical & General Office Expenses	(389)	0	33,085	5,917	0	0	0	0	0	0	0	38,613	21
22	Employee Benefits & Payroll Taxes	0	0	0	4,762	0	0	0	0	0	0	0	4,762	22
23	Inservice Training & Education	0	0	338	136	0	0	0	0	0	0	0	474	23
24	Travel and Seminar	0	0	104	0	0	0	0	0	0	0	0	104	24
25	Other Admin. Staff Transportation	0	0	1,630	2,388	0	0	0	0	0	0	0	4,018	25
26	Insurance-Prop.Liab.Malpractice	0	0	676	0	0	0	0	0	0	0	0	676	26
27	Other (specify):*	0	0	8,881	0	0	0	0	0	0	0	0	8,881	27
28	TOTAL General Administration	(539)	(76,342)	45,982	21,810	0	(9,089)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(5,792)	(68,309)	45,982	21,845	0	(6,274)	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number White Oaks Rehabilitation & Health Care Center# 0047910

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	(45,779)	0	2,674	16,151	0	0	0	0	0	0	0	(26,954)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,678)	0	4,113	16,364	0	0	0	0	0	0	0	13,799	32
33	Real Estate Taxes	0	0	411	0	0	0	0	0	0	0	0	411	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	393	1	0	0	0	0	0	0	0	394	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(52,457)	0	7,591	32,516	0	(12,350)	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):*	(174,021)	0	0	0	0	0	0	0	0	0	0	(174,021)	43
44	TOTAL Special Cost Centers	(174,021)	0	0	0	0	0	0	0	0	0	0	(174,021)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(232,270)	(68,309)	53,573	54,361	0	0	0	0	0	0	0	(192,645)	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%	\$ 3,245	\$ 3,245	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	73	73	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	31	31	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	320	320	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	1,572	1,572	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	586	586	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	1,964	1,964	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%	242	242	10
11	V	17 Administrative	128,000	Petersen Health Care, Inc.	100.00%	47,109	(80,891)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	4,549	4,549	12
13	V							13
14	Total		\$ 128,000			\$ 59,691	\$ * (68,309)	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%	\$ 1,268	\$	1,268	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	33,085		33,085	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	338		338	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	104		104	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	1,630		1,630	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	676		676	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	8,881		8,881	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	2,674		2,674	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	4,113		4,113	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	411		411	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%	393		393	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		\$			\$ 53,573	\$ *	53,573	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%	35	35	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%	7,671	7,671	25	
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Care II, Inc.	100.00%	936	936	26	
27	V	21 Clerical and General Office		Petersen Health Care II, Inc.	100.00%	5,917	5,917	27	
28	V	22 Employee Benefits & Payroll		Petersen Health Care II, Inc.	100.00%	4,762	4,762	28	
29	V	23 Inservice Training & Education		Petersen Health Care II, Inc.	100.00%	136	136	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%	2,388	2,388	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%	16,151	16,151	34	
35	V	32 Interest		Petersen Health Care II, Inc.	100.00%	16,364	16,364	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%	1	1	38	
39	Total		\$			\$ 54,361	\$ *	54,361	39

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

Facility Name & ID Number White Oaks Rehabilitation & Health Care C # 0047910 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Petersen	President	Administrative	100.00	157,004	0.73	1.21	Salary	\$ 2,109	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	\$ 2,109		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 White Oaks Rehabilitation & Health Care Center # 0047910 Report Period Beginning: 1/1/2009 Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,493,044	75	\$ 261,102	\$ 259,584	18,554	\$ 3,245	1
2	2	Food	Resident Days	1,493,044	75	5,864	0	18,554	73	2
3	3	Housekeeping	Resident Days	1,493,044	75	2,458	0	18,554	31	3
4	4	Laundry	Resident Days	1,493,044	75	0	0	18,554	0	4
5	5	Utilities	Resident Days	1,493,044	75	25,776	0	18,554	320	5
6	6	Maintenance	Resident Days	1,493,044	75	126,463	107,810	18,554	1,572	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	47,148	0	18,554	586	7
8	10	Nursing and Medical Records	Resident Days	1,493,044	75	158,020	151,697	18,554	1,964	8
9	10A	Therapy	Resident Days	1,493,044	75	0	0	18,554	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	19,462	0	18,554	242	10
11	17	Administrative	Resident Days	1,493,044	75	3,315,953	3,315,953	18,554	47,109	11
12	19	Professional Services	Resident Days	1,493,044	75	366,089	0	18,554	4,549	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,493,044	75	102,022	0	18,554	1,268	13
14	21	Clerical and General Office	Resident Days	1,493,044	75	2,662,394	2,253,243	18,554	33,085	14
15	23	Inservice Training & Education	Resident Days	1,493,044	75	27,176	0	18,554	338	15
16	24	Travel and Seminar	Resident Days	1,493,044	75	8,381	0	18,554	104	16
17	25	Other Admin. Staff Transport.	Resident Days	1,493,044	75	131,200	0	18,554	1,630	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,493,044	75	54,425	0	18,554	676	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	714,650	0	18,554	8,881	19
20	30	Depreciation	Resident Days	1,493,044	75	215,197	0	18,554	2,674	20
21	32	Interest	Resident Days	1,493,044	75	330,981	0	18,554	4,113	21
22	33	Real Estate Taxes	Resident Days	1,493,044	75	33,065	0	18,554	411	22
23	34	Rent-Facility and Grounds	Resident Days	1,493,044	75	0	0	18,554	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,493,044	75	31,635	0	18,554	393	24
25	TOTALS					\$ 8,639,461	\$ 6,088,287		\$ 113,264	25

Facility Name & ID Number White Oaks Rehabilitation & Health Care Center # 0047910 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		18,554		1
2	2	Food	Resident Days	336,837	13		18,554		2
3	3	Housekeeping	Resident Days	336,837	13		18,554		3
4	4	Laundry	Resident Days	336,837	13		18,554		4
5	5	Utilities	Resident Days	336,837	13		18,554		5
6	6	Maintenance	Resident Days	336,837	13	628	18,554	35	6
7	7	Mgmt. Allocation of Benefits	Resident Days	336,837	13		18,554		7
8	10	Nursing and Medical Records	Resident Days	336,837	13		18,554		8
9	15	Mgmt. Allocation of Benefits	Resident Days	336,837	13		18,554		9
10	17	Administrative	Resident Days	336,837	13		18,554		10
11	19	Professional Services	Resident Days	336,837	13	139,269	18,554	7,671	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	336,837	13	17,001	18,554	936	12
13	21	Clerical and General Office	Resident Days	336,837	13	107,426	18,554	5,917	13
14	22	Employee Benefits & Payroll	Resident Days	336,837	13	86,458	18,554	4,762	14
15	23	Inservice Training & Education	Resident Days	336,837	13	2,464	18,554	136	15
16	24	Travel and Seminar	Resident Days	336,837	13		18,554		16
17	25	Other Admin. Staff Transport.	Resident Days	336,837	13	43,354	18,554	2,388	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	336,837	13		18,554		18
19	27	Mgmt. Allocation of Benefits	Resident Days	336,837	13		18,554		19
20	30	Depreciation	Resident Days	336,837	13	293,215	18,554	16,151	20
21	32	Interest	Resident Days	336,837	13	297,084	18,554	16,364	21
22	33	Real Estate Taxes	Resident Days	336,837	13		18,554		22
23	34	Rent-Facility and Grounds	Resident Days	336,837	13		18,554		23
24	35	Rent-Equipment & Vehicles	Resident Days	336,837	13	26	18,554	1	24
25	TOTALS					\$ 986,925	\$	\$ 54,361	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	2	3	4	5	6		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	US Bank		X	Mortgage	Varies	05/06/06	\$ 1,800,000	\$ 1,636,241	05/05/09	Varies	\$ 137,465	1						
2												2						
3							Interest Income Offset				(6,678)	3						
4							Home Office Allocation-PHC				4,113	4						
5							Home Office Allocation-PHC II				16,364	5						
Working Capital																		
6												6						
7												7						
8												8						
9	TOTAL Facility Related						\$ 1,800,000	\$ 1,636,241			\$ 151,264	9						
B. Non-Facility Related*																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 1,800,000	\$ 1,636,241			\$ 151,264	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.		\$	30,000	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	\$	30,322	2
3. Under or (over) accrual (line 2 minus line 1).		\$	322	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	31,200	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.)		\$	411	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	31,933	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2004		8
	2005		9
	2006	27,362	10
	2007	28,888	11
	2008	30,322	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>30,321.54</u>	\$ <u>30,321.54</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: 18,008 B. General Construction Type: Exterior Brick Frame Block Number of Stories 1

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

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

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

N/A

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Facility</u>	<u>125,030</u>	<u>2006</u>	<u>\$ 60,000</u>	1
2					2
3	TOTALS	125,030		\$ 60,000	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	65		2006	1965	\$ 2,015,000	\$	25	\$ 53,734	\$ 53,734	\$ 214,935	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Land Improvements		2006		15,000		15	1,000	1,000	3,667	9
10	Sidewalks		2006		4,240		15	283	283	1,108	10
11	Plumbing		2006		5,360		20	268	268	938	11
12	Sign		2006		3,118		10	312	312	1,084	12
13	Water Heaters		2007		7,053		10	705	705	1,763	13
14	Fire/Sprinkler System		2007		48,100		15	3,206	3,206	8,015	14
15	Water Heater		2008		5,196		10	520	520	780	15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27	Land Improvements Booked					1,283			(1,283)		27
28	Building Booked					80,600			(80,600)		28
29	Building Improvement Booked					5,656			(5,656)		29
30											30
31											31
32	2009-Home Office Allocation-Land Improvements				610			38	38		32
33	2009-Home Office Allocation-Building Improvements				9,121			219	219		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 White Oaks Rehabilitation & Health Care Center

0047910

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

XI. OWNERSHIP COSTS (continued)

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

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,112,798	\$ 87,539		\$ 60,285	\$ (27,254)	\$ 232,290	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	\$ 396,863	\$ 58,212	\$ 39,687	\$ (18,525)	10 yrs.	\$ 153,570	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Home Office Allocation			18,825	18,825			74
75	TOTALS	\$ 396,863	\$ 58,212	\$ 58,512	\$ 300		\$ 153,570	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	2007 Ford Cargo Van	2007	\$ 28,602	\$ 5,720	\$ 5,720	\$	5	\$ 14,300	76
77										77
78										78
79										79
80	TOTALS			\$ 28,602	\$ 5,720	\$ 5,720	\$		\$ 14,300	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)	\$ 2,598,263	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 151,471	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 124,517	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (26,954)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 400,160	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 White Oaks Rehabilitation & Health Care Center

0047910

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

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: \$ 11,106 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.

White Oak Rehabilitation & Health Care Center

0047910

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	\$ 5,850
Dishwasher	1,092
Laundry Equipment	1,728
Copier	2,042
Home Office Allocation	394
	<u>11,106</u>

Facility Name & ID Number White Oaks Rehabilitation & Health Care Center # 0047910 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>
---	---	--

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		3		4 Outside Practitioner (other than consultant)		5	6	7	8
			Units of Service	Cost	Units	Cost	Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)			
1	Licensed Occupational Therapist	10A(1,3)	5710 hrs	\$ 173,594		\$	\$		5,710	\$ 173,594	1	
2	Licensed Speech and Language Development Therapist	10A(1,3)	3437 hrs	168,692					3,437	168,692	2	
3	Licensed Recreational Therapist		hrs								3	
4	Licensed Physical Therapist	10A(1,2,3)	6352 hrs	179,644				556	6,352	180,200	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					211,853		211,853	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10	
11	Academic Education		hrs								11	
12	Other (specify): <u>PT Consultant</u>										12	
13	Other (specify): <u>Respiratory Therapist</u>					7	110		7	110	13	
14	TOTAL			\$ 521,930	7	\$ 110	\$ 212,409		15,506	\$ 734,449	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 White Oaks Rehabilitation & Health Care Center# 0047910Report 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	\$ 995,396	\$ 995,396	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>N/A</u>)	783,654	783,654	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	32,402	32,402	6
7	Other Prepaid Expenses	11,507	11,507	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,822,959	\$ 1,822,959	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		60,000	13
14	Buildings, at Historical Cost	2,094,240	2,024,121	14
15	Leasehold Improvements, at Historical Cost	60,349	88,677	15
16	Equipment, at Historical Cost	428,582	425,465	16
17	Accumulated Depreciation (book methods)	(529,690)	(400,160)	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>Due From Prior Owner</u>	21,617	21,617	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,075,098	\$ 2,219,720	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,898,057	\$ 4,042,679	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 725,333	\$ 725,333	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	109,445	109,445	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,950	2,950	31
32	Accrued Real Estate Taxes(Sch.IX-B)	31,200	31,200	32
33	Accrued Interest Payable	12,205	12,205	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	72,209	72,209	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 953,342	\$ 953,342	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,636,241	1,636,241	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,636,241	\$ 1,636,241	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,589,583	\$ 2,589,583	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,308,474	\$ 1,453,096	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,898,057	\$ 4,042,679	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,261,201	1
2	Restatements (describe):		2
3	2008 Bad Debt Allowance Entered After CR Completion	(50,000)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,211,201	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	97,273	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)	\$ 97,273	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)	\$ 1,308,474	24 *

* This must agree with page 17, line 47.

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,386,214	1
2	Discounts and Allowances for all Levels	(53,369)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,332,845	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	764,735	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 764,735	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,374	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	348,567	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	24,527	20
21	Other Medical Services	4,896	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 380,364	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	6,678	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 6,678	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	3,268	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,268	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,487,890	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	516,903	31
32	Health Care	1,625,347	32
33	General Administration	495,735	33
B. Capital Expense			
34	Ownership	331,170	34
C. Ancillary Expense			
35	Special Cost Centers	385,874	35
36	Provider Participation Fee	35,588	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,390,617	40
41	Income before Income Taxes (line 30 minus line 40)**	97,273	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 97,273	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 a 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 White Oaks Rehabilitation & Health Care Center

0047910

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	1,725	1,805	\$ 51,215	\$ 28.37	1
2	Assistant Director of Nursing	1,733	1,733	38,481	22.20	2
3	Registered Nurses	5,510	5,558	109,243	19.66	3
4	Licensed Practical Nurses	17,051	17,541	295,566	16.85	4
5	CNAs & Orderlies	44,432	44,988	399,156	8.87	5
6	CNA Trainees					6
7	Licensed Therapist	4,150	4,151	207,970	50.10	7
8	Rehab/Therapy Aides	11,348	11,348	313,960	27.67	8
9	Activity Director	1,777	1,857	15,757	8.49	9
10	Activity Assistants					10
11	Social Service Workers	2207	2,297	24,202	10.54	11
12	Dietician					12
13	Food Service Supervisor	2,056	2,056	22,416	10.90	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,809	9,975	78,858	7.91	15
16	Dishwashers					16
17	Maintenance Workers	2,052	2,156	26,594	12.33	17
18	Housekeepers	8,417	8,638	70,187	8.13	18
19	Laundry	3,038	3,167	25,118	7.93	19
20	Administrator	2,080	2,080	60,000	28.85	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,824	1,964	21,848	11.12	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Care Plan Coord.</u>	1,881	1,988	41,455	20.85	33
34	TOTAL (lines 1 - 33)	121,090	123,302	\$ 1,802,026 *	\$ 14.61	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 9,000	9(3)	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 600	10(3)	39
40	Physical Therapy Consultant	Monthly 19,814	10(3)	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)	\$ 29,414		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	
Janice Franklin	Administrator	0	\$ 60,000	Workers' Compensation Insurance	\$ 31,638	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance	25,834	Advertising: Employee Recruitment	1,757	
				FICA Taxes	132,286	Health Care Worker Background Check		
				Employee Health Insurance	25,134	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks	319	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	475	
				Employee Relations	5,312	Miscellaneous Dues & Subscriptions	150	
				Employee Retirement	208	IHCA Dues	1,500	
						Home Office Allocation	2,204	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 60,000			Less: Public Relations Expense	(150)	
B. Administrative - Other						Non-allowable advertising	()	
Description			Amount			Yellow page advertising	()	
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 128,000					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 128,000	TOTAL (agree to Schedule V, line 22, col.8)	\$ 220,412	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 11,116	
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		\$ 2,700				Out-of-State Travel	\$
AT & T	Computer Services		605					
LTC Solutions	Computer Services		1,700					
SimpleLTC, Inc.	Computer Services		81	N/A			In-State Travel	
Heyl, Royster, Voelker & Allen	Legal Services		451					
Brown & James	Legal Services		18,065				Seminar Expense	
							Home Office Allocation	104
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 23,602	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 104

* Attach copy of IMRF notifications

**See instructions.

White Oaks Rehabilitation & Health Care Center
0047910
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)		23,602
Home Office Allocation		
Heyl, Royster, Voelker & Allen	Legal	29
GoffWilson, P.A.	Legal	41
Jackson Lewis	Legal	322
Peter Gartelos	Legal	31
Misc.	Legal	28
Ginoli & Company	Accountants	2,153
Miscellaneous Vendors	Computer Services	30
Emdeon Business Services	Computer Services	14
Advanced Answers on Demand	Computer Services	1,748
Access 2 Go	Computer Services	168
Ivans	Computer Services	104
Kemper Technology	Computer Services	475
VisionShare	Computer Services	148
MediFax	Computer Services	60
Logmein	Computer Services	26
Charter Communications	Computer Services	1
CDW	Computer Services	265
Simple LTC	Computer Services	403
Polaris Group	Other Professional Services	5,793
Donna Howard & Assoc.	Other Professional Services	99
Miscellaneous Vendors	Miscellaneous	282
Total (agree to Schedule V, line 19, column 8)		<u>35,822</u>

White Oaks Rehabilitation & Health Care Center
0047910
Period Beginning 1/1/2009
Period End 12/31/2009

Schedule 21B

XIX. SUPPORT SCHEDULE
Legal Fees

Facility

Vendor/Payee	Invoice Total	Allocation %	Total
Brown & James	3,556.40	100%	3,556
Brown & James	7,027.91	100%	7,028
Brown & James	1,587.18	100%	1,587
Brown & James	531.80	100%	532
Brown & James	3,763.50	100%	3,764
Heyl, Royster, Voelker, & Allen	46.00	100%	46
Brown & James	1,517.03	100%	1,517
Brown & James	81.10	100%	81
Heyl, Royster, Voelker, & Allen	405.44	100%	405
Home Office Allocation			
Heyl, Royster, Voelker, and Allen	2,414.77	1.20%	29
GoffWilson	3,425.00	1.20%	41
Jackson Lewis	27,043.20	1.20%	322
Peter Gartelos	2,612.50	1.20%	31
Miscellaneous Vendors	2,327.62	1.20%	28
Total Legal Fees			<u><u>18,967</u></u>

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	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 White Oaks Rehabilitation & Health Care Center# 0047910Report Period Beginning: 1/1/2009Ending: 12/31/2009**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. 1,500 IHCA
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? No
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 3,189 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. \$ 35,588
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,374
- (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.