



Facility Name & ID Number Cisne Rehabilitation & Health Care Center

# 0047423 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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	11	Skilled (SNF)	11	4,015	1
2		Skilled Pediatric (SNF/PED)			2
3	24	Intermediate (ICF)	24	8,760	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	35	TOTALS	35	12,775	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF			1,367	1,367		8
9	SNF/PED						9
10	ICF	6,544	2,642		9,186		10
11	ICF/DD						11
12	SC						12
13	DD 16 OR LESS						13
14	TOTALS	6,544	2,642	1,367	10,553		14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.61%

D. How many bed-hold days during this year were paid by the Department? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

Meals on Wheels

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
 YES  NO  Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
 YES  NO

I. On what date did you start providing long term care at this location?  
 Date started 10/1/2005

J. Was the facility purchased or leased after January 1, 1978?  
 YES  Date 10/1/2005 NO

K. Was the facility certified for Medicare during the reporting year?  
 YES  NO  If YES, enter number of beds certified 11 and days of care provided 1,299

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: 12/31/2010 Fiscal Year: 12/31/2010

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

Facility Name & ID Number Cisne Rehabilitation & Health Care Center # 0047423 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

**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
	<b>A. General Services</b>										
1	Dietary	84,330	6,349		90,679		90,679	1,966	92,645		1
2	Food Purchase		62,307		62,307		62,307	(5,244)	57,063		2
3	Housekeeping	31,217	13,494		44,711		44,711	23	44,734		3
4	Laundry	16,488	5,542		22,030		22,030		22,030		4
5	Heat and Other Utilities			33,127	33,127		33,127	195	33,322		5
6	Maintenance	23,669	9,283	13,760	46,712		46,712	1,144	47,856		6
7	Other (specify):* <u>Home Off. Ben. All.</u>							461	461		7
8	<b>TOTAL General Services</b>	155,704	96,975	46,887	299,566		299,566	(1,455)	298,111		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			8,400	8,400		8,400		8,400		9
10	Nursing and Medical Records	477,037	46,033	2,577	525,647		525,647	30	525,677		10
10a	Therapy	21,218	148		21,366		21,366		21,366		10a
11	Activities	27,665	167	2,865	30,697		30,697	(46)	30,651		11
12	Social Services	21,383			21,383		21,383		21,383		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Off. Ben. All.</u>										15
16	<b>TOTAL Health Care and Programs</b>	547,303	46,348	13,842	607,493		607,493	(16)	607,477		16
	<b>C. General Administration</b>										
17	Administrative			118,000	118,000		118,000	(75,659)	42,341		17
18	Directors Fees										18
19	Professional Services			3,884	3,884		3,884	2,643	6,527		19
20	Dues, Fees, Subscriptions & Promotions			2,885	2,885		2,885	987	3,872		20
21	Clerical & General Office Expenses		4,706	7,421	12,127		12,127	20,190	32,317		21
22	Employee Benefits & Payroll Taxes			87,475	87,475		87,475	1,702	89,177		22
23	Inservice Training & Education							141	141		23
24	Travel and Seminar							16	16		24
25	Other Admin. Staff Transportation			6,401	6,401		6,401	1,761	8,162		25
26	Insurance-Prop.Liab.Malpractice			13,539	13,539		13,539	292	13,831		26
27	Other (specify):* <u>Home Off. Ben. All.</u>							7,984	7,984		27
28	<b>TOTAL General Administration</b>		4,706	239,605	244,311		244,311	(39,943)	204,368		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	703,007	148,029	300,334	1,151,370		1,151,370	(41,414)	1,109,956		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 Cisne Rehabilitation & Health Care Center

#0047423

Report Period Beginning:

1/1/2010

Ending:

12/31/2010

## 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	
	<b>D. Ownership</b>											
30	Depreciation			20,150	20,150		20,150	1,780	21,930			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			6,073	6,073		6,073	13,840	19,913			32
33	Real Estate Taxes			11,363	11,363		11,363	(54)	11,309			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			6,293	6,293		6,293	270	6,563			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			43,879	43,879		43,879	15,836	59,715			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		65,444		65,444		65,444		65,444			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			19,163	19,163		19,163		19,163			42
43	Other (specify):* <b>Non-allowable Cost</b>		388	11,625	12,013		12,013	(12,013)				43
44	<b>TOTAL Special Cost Centers</b>		65,832	30,788	96,620		96,620	(12,013)	84,607			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	703,007	213,861	375,001	1,291,869		1,291,869	(37,591)	1,254,278			45

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

**VI. ADJUSTMENT DETAIL**

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

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(438)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,109)	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	(1,004)	30		9
10	Interest and Other Investment Income	(289)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(30)	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	(2)	43		24
25	Fund Raising, Advertising and Promotional	(1,396)	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 Page 5A	(11,911)	Various		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (19,179)		\$	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	
		<b>Amount</b>	<b>Reference</b>	
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)	(18,412)	Various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (18,412)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (37,591)		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
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
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		X		45
46	Other-Attach Schedule		X		46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

<b>BHF USE ONLY</b>							
48		49		50		51	52

Cisne Rehabilitation & Health Care Center

ID# 0047423

Report Period Beginning: 1/1/2010

Ending: 12/31/2010

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Disallowed Special Events	(421)	43	1
2	Offset Meals on Wheels Revenue	(4,806)	2	2
3	Offset Miscellaneous Office Supplies Revenue	(250)	21	3
4	Resident Flowers	(335)	43	4
5	Labs-Part A	(4,196)	43	5
6	X-Rays-Part A	(1,524)	43	6
7	Offset Transportation Revenue	(46)	11	7
8	Disallow Real Estate Tax penalty	(333)	33	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
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31				31
32				32
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34				34
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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	<b>Total</b>	(11,911)		49

**VII. RELATED PARTIES**

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 1,966	\$ 1,966	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	0		2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	23	23	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	195	195	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	1,144	1,144	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	461	461	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	30	30	8
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		10
11	V	17 Administrative	118,000	Petersen Health Care, Inc.	100.00%	42,341	(75,659)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	2,178	2,178	12
13	V							13
14	Total		\$ 118,000			\$ 48,338	\$ * (69,662)	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 & Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 539	\$	539	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	19,564		19,564	16
17	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	141		141	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	16		16	18
19	V	25 Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	1,761		1,761	19
20	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	292		292	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	7,984		7,984	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	2,264		2,264	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	2,609		2,609	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	279		279	24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0			25
26	V	35 Rent-Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	270		270	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		\$			\$ 35,719	\$ *	35,719	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 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%	0		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	12 Social Services		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%	465	465	25
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Operations, LLC	100.00%	448	448	26
27	V	21 Clerical and General Office		Petersen Health Operations, LLC	100.00%	876	876	27
28	V	22 Employee Benefits & Payroll		Petersen Health Operations, LLC	100.00%	1,702	1,702	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%	0		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%	0		33
34	V	30 Depreciation		Petersen Health Operations, LLC	100.00%	520	520	34
35	V	32 Interest		Petersen Health Operations, LLC	100.00%	11,520	11,520	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		\$			\$ 15,531	\$ *	15,531

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

Facility Name & ID Number Cisne Rehabilitation & Health Care Center # 0047423 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

## 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	180,909	0.4	0.67	Salary	\$ 1,341	L17, C7	1
2											2
3											3
4											4
5		See Attached Schedule 7A									5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 1,341		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 Cisne Rehabilitation & Health Care Center # 0047423 Report Period Beginning: 1/1/2010 Ending: 2/31/2010

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	1,527,029	77	\$ 284,427	\$ 283,010	10,553	\$ 1,966	1
2	2	Food	Resident Days	1,527,029	77	0	0	10,553	0	2
3	3	Housekeeping	Resident Days	1,527,029	77	3,369	0	10,553	23	3
4	4	Laundry	Resident Days	1,527,029	77	0	0	10,553	0	4
5	5	Utilities	Resident Days	1,527,029	77	28,267	0	10,553	195	5
6	6	Maintenance	Resident Days	1,527,029	77	165,545	121,901	10,553	1,144	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,527,029	77	66,650	0	10,553	461	7
8	10	Nursing and Medical Records	Resident Days	1,527,029	77	4,339	0	10,553	30	8
9	10A	Therapy	Resident Days	1,527,029	77	0	0	10,553	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,527,029	77	0	0	10,553	0	10
11	17	Administrative	Resident Days	1,527,029	77	5,157,152	5,157,152	10,553	42,341	11
12	19	Professional Services	Resident Days	1,527,029	77	315,156	0	10,553	2,178	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,527,029	77	78,050	0	10,553	539	13
14	21	Clerical and General Office	Resident Days	1,527,029	77	2,830,968	2,420,380	10,553	19,564	14
15	23	Inservice Training & Education	Resident Days	1,527,029	77	20,336	0	10,553	141	15
16	24	Travel and Seminar	Resident Days	1,527,029	77	2,344	0	10,553	16	16
17	25	Other Admin. Staff Transport.	Resident Days	1,527,029	77	254,752	0	10,553	1,761	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,527,029	77	42,233	0	10,553	292	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,527,029	77	1,155,252	0	10,553	7,984	19
20	30	Depreciation	Resident Days	1,527,029	77	327,648	0	10,553	2,264	20
21	32	Interest	Resident Days	1,527,029	77	377,597	0	10,553	2,609	21
22	33	Real Estate Taxes	Resident Days	1,527,029	77	40,405	0	10,553	279	22
23	34	Rent-Facility and Grounds	Resident Days	1,527,029	77	0	0	10,553	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,527,029	77	39,061	0	10,553	270	24
25	TOTALS					\$ 11,193,551	\$ 7,982,443		\$ 84,057	25

Facility Name & ID Number Cisne Rehabilitation & Health Care Center # 0047423 Report Period Beginning: 1/1/2010 Ending: 2/31/2010

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 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

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	389,552	21	\$	\$	10,553	\$	1
2	2	Food	Resident Days	389,552	21			10,553		2
3	3	Housekeeping	Resident Days	389,552	21			10,553		3
4	4	Laundry	Resident Days	389,552	21			10,553		4
5	5	Utilities	Resident Days	389,552	21			10,553		5
6	6	Maintenance	Resident Days	389,552	21			10,553		6
7	7	Mgmt. Allocation of Benefits	Resident Days	389,552	21			10,553		7
8	10	Nursing and Medical Records	Resident Days	389,552	21			10,553		8
9	12	Social Services	Resident Days	389,552	21			10,553		9
10	17	Administrative	Resident Days	389,552	21			10,553		10
11	19	Professional Services	Resident Days	389,552	21	17,164		10,553	465	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	389,552	21	16,534		10,553	448	12
13	21	Clerical and General Office	Resident Days	389,552	21	32,356		10,553	876	13
14	22	Employee Benefits & Payroll	Resident Days	389,552	21	62,830		10,553	1,702	14
15	23	Inservice Training & Education	Resident Days	389,552	21			10,553		15
16	24	Travel and Seminar	Resident Days	389,552	21			10,553		16
17	25	Other Admin. Staff Transport.	Resident Days	389,552	21			10,553		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	389,552	21			10,553		18
19	27	Mgmt. Allocation of Benefits	Resident Days	389,552	21			10,553		19
20	30	Depreciation	Resident Days	389,552	21	19,207		10,553	520	20
21	32	Interest	Resident Days	389,552	21	425,239		10,553	11,520	21
22	33	Real Estate Taxes	Resident Days	389,552	21			10,553		22
23	34	Rent-Facility and Grounds	Resident Days	389,552	21			10,553		23
24	35	Rent-Equipment & Vehicles	Resident Days	389,552	21			10,553		24
25	TOTALS					\$ 573,330	\$		\$ 15,531	25

Facility Name & ID Number

Cisne Rehabilitation & Health Care Center

# 0047423

Report Period Beginning:

1/1/2010

Ending:

12/31/2010

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1	2	3	4	5	6	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																			
<b>Long-Term</b>																			
1	Bank of America		X	Mortgage	Varies	1/19/07	\$ 125,000	\$ 119,687	9/20/2010	Varies	\$ 6,073	1							
2												2							
3							Interest Income Offset				(289)	3							
4							Home Office Allocation-PHC				2,609	4							
5							Home Office Allocation-PHO				11,520	5							
<b>Working Capital</b>																			
6												6							
7												7							
8												8							
9	<b>TOTAL Facility Related</b>						\$ 125,000	\$ 119,687			\$ 19,913	9							
<b>B. Non-Facility Related*</b>																			
10												10							
11												11							
12												12							
13												13							
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14							
15	<b>TOTALS (line 9+line14)</b>						\$ 125,000	\$ 119,687			\$ 19,913	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**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>			
1. Real Estate Tax accrual used on 2009 report.			\$ <b>10,200</b>	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.)	2009		\$ <b>10,430</b>	2	
3. Under or (over) accrual (line 2 minus line 1).			\$ <b>230</b>	3	
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)			\$ <b>10,800</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$	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.					
<b>TOTAL REFUND</b>	\$	For	Tax Year.		
			<b>Home Office Allocation</b>	<b>279</b>	
			\$	6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$ <b>11,309</b>	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2005	8,946	8		
	2006	9,312	9		
	2007	9,300	10		
	2008	9,923	11		
	2009	10,430	12		
<b>Accrual based on prior year tax bill.</b>					
				<b>FOR BHF USE ONLY</b>	
	13	FROM R. E. TAX STATEMENT FOR 2009	\$		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.**



**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 9,413 B. General Construction Type: Exterior Brick Veneer Frame Wood Number of Stories 1

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

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

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

N/A

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

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

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

**XI. OWNERSHIP COSTS:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>75,359</u>	<u>2005</u>	<u>\$ 9,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>75,359</b>		<b>\$ 9,000</b>	<b>3</b>

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	35	2005	1970	\$ 176,500	\$	25	\$ 7,060	\$ 7,060	\$ 38,830
5									
6									
7									
8									
Improvement Type**									
9	Original Land Improvements	2005		10,000		15	667	667	3,668
10	Waterline	2005		1,634		15	109	109	599
11	Carpet	2006		1,269		5	254	254	1,143
12	Gutter	2006		2,750		25	110	110	495
13	Sewer Line	2007		3,500		20	175	175	613
14	Condenser Unit	2009		5,018		7	717	717	1,075
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30	Land Improvements Booked				1,009			(1,009)	
31	Building Booked				7,090			(7,090)	
32	Building Improvement Booked				1,080			(1,080)	
33									
34	2010-Home Office Allocation-Building Improvements			5,072			122	122	
35	2010-Home Office Allocation-Land Improvements			473			26	26	
36									

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 206,216	\$ 9,179		\$ 9,240	\$ 61	\$ 46,423	70

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

Facility Name & ID Number Cisne Rehabilitation & Health Care Center

# 0047423

Report Period Beginning:

1/1/2010

Ending:

12/31/2010

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	\$ 52,213	\$ 7,129	\$ 7,034	\$ (95)	5-10 yrs.	\$ 34,515	71
72	Current Year Purchases	4,391	575	220	(355)	10 yrs.	220	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			2,636	2,636			74
75	TOTALS	\$ 56,604	\$ 7,704	\$ 9,890	\$ 2,186		\$ 34,735	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	2010 Ford Van	2010	\$ 28,001	\$ 3,267	\$ 2,800	\$ (467)	5 yrs.	\$ 2,800	76
77										77
78										78
79										79
80	TOTALS			\$ 28,001	\$ 3,267	\$ 2,800	\$ (467)		\$ 2,800	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)	\$ 299,821	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 20,150	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 21,930	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,780	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 83,958	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	N/A	\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?  YES  NO

If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

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

16. Rental Amount for movable equipment: \$ 6,563 Description: See Attached Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18			N/A		18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_ /2011 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2012 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2013 \$ \_\_\_\_\_

\* 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.

Cisne Rehabilitation & Health Care Center  
0047423  
Period Beginning 1/1/2010  
Period End 12/31/2010

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$	2,599
Dishwasher		835
Copier		2,859
Home Office Allocation		270
		<u>6,563</u>

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**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)	
<b>TOTAL TRAINED</b>	

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	10A(1)	48	hrs	\$ 1,471					48	\$ 1,471	1
2	Licensed Speech and Language Development Therapist	10A(1)	165	hrs	9,022					165	9,022	2
3	Licensed Recreational Therapist			hrs								3
4	Licensed Physical Therapist	10A(1), 10A(2)	87	hrs	5,130			148		87	5,278	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				65,444			65,444	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	<b>TOTAL</b>				\$ 15,623			\$ 65,592		300	\$ 81,215	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 Cisne Rehabilitation & Health Care Center# 0047423Report Period Beginning: 1/1/2010Ending: 12/31/2010

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2010

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 180,619	\$ 180,619	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>5,000</u> )	137,065	137,065	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	9,137	9,137	6
7	Other Prepaid Expenses	4,944	4,944	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Prepaid Management fees</u>	45,000	45,000	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 376,765	\$ 376,765	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	24,134	9,000	13
14	Buildings, at Historical Cost	176,500	181,572	14
15	Leasehold Improvements, at Historical Cost	9,037	24,644	15
16	Equipment, at Historical Cost	84,605	84,605	16
17	Accumulated Depreciation (book methods)	(82,270)	(83,958)	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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 212,006	\$ 215,863	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 588,771	\$ 592,628	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 151,284	\$ 151,284	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	12,478	12,478	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,478	9,478	31
32	Accrued Real Estate Taxes(Sch.IX-B)	10,800	10,800	32
33	Accrued Interest Payable	537	537	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Payroll Withholdings</u>	12,815	12,815	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 197,392	\$ 197,392	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable	119,687	119,687	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 119,687	\$ 119,687	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 317,079	\$ 317,079	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 271,692	\$ 275,549	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 588,771	\$ 592,628	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>22,505</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Rounding</b>	<b>2</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>22,507</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>249,185</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>249,185</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>271,692</b>	<b>24</b> *

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

Facility Name & ID Number Cisne Rehabilitation & Health Care Center# 0047423Report Period Beginning: 1/1/2010Ending: 12/31/2010

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 1,359,474	1
2	Discounts and Allowances for all Levels	(138,800)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 1,220,674</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	200,199	6
7	Oxygen	97	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 200,296</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
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	5,244	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	105,411	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	4,887	20
21	Other Medical Services	3,957	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 119,499</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	289	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 289</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Miscellaneous Revenue	250	28
28a	Transportation Revenue	46	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 296</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 1,541,054</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	299,566	31
32	Health Care	607,493	32
33	General Administration	244,311	33
<b>B. Capital Expense</b>			
34	Ownership	43,879	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	77,457	35
36	Provider Participation Fee	19,163	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 1,291,869</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>249,185</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 249,185</b>	<b>43</b>

\* 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 **Cisne Rehabilitation & Health Care Center**

# **0047423**

Report Period Beginning:

1/1/2010

Ending:

12/31/2010

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,112	2,112	\$ 49,598	\$ 23.48	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,878	5,178	100,633	19.43	3
4	Licensed Practical Nurses	4,932	4,997	73,828	14.77	4
5	CNAs & Orderlies	26,959	27,849	225,754	8.11	5
6	CNA Trainees					6
7	Licensed Therapist	290	300	15,623	52.08	7
8	Rehab/Therapy Aides	114	178	5,595	31.43	8
9	Activity Director	2,080	2,080	22,186	10.67	9
10	Activity Assistants					10
11	Social Service Workers	2,080	2,080	21,383	10.28	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	20,802	10.00	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,862	7,940	63,528	8.00	15
16	Dishwashers					16
17	Maintenance Workers	1,937	1,938	23,669	12.21	17
18	Housekeepers	3,587	3,794	31,217	8.23	18
19	Laundry	1,840	1,989	16,488	8.29	19
20	Administrator	2,080	2,080	41,000	19.71	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)					30
31	Medical Records					31
32	Other Health C: Care Plan Coord	1,387	1,387	27,224	19.63	32
33	Other(specify) <u>Transportation</u>	635	673	5,479	8.14	33
34	TOTAL (lines 1 - 33)	64,853	66,655	\$ 744,007 *	\$ 11.16	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 8,400	9(3)	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 1,662	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)	\$ 10,062		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



**Cisne Rehabilitation & Health Care Center**

**0047423**

**Period Beginning 1/1/2010**

**Period End 12/31/2010**

**Schedule 21A**

**XIX. SUPPORT SCHEDULE**

**C. Professional Services**

<b>Vendor/Payee</b>	<b>Type</b>	<b>Amount</b>
Total (agree to Schedule V, line 19, column 3)		3,884

**Home Office Allocation**

Heyl, Royster, Voelker & Allen	Legal	2
Healthcare Resources International	Legal	27
Ginoli & Company	Accountants	850
Bank of America	Accountants	85
Miscellaneous Vendors	Computer Services	12
VisionShare	Computer Services	116
Advanced Answers on Demand	Computer Services	728
Access 2 Go	Computer Services	118
Kemper Technology	Computer Services	100
MediFax	Computer Services	42
LogmeIn	Computer Services	30
Simple LTC	Computer Services	464
Optimizer Systems	Other Professional I	17
Clifton Gunderson	Other Professional I	52
Total (agree to Schedule V, line 19, column 8)		<u>6,527</u>

Period Beginning 1/1/2010  
Period End 12/31/2010

Schedule 21B

XIX. SUPPORT SCHEDULE

Legal Fees

Facility

Vendor/Payee	Invoice Total	Allocation %	Total
		100%	-
<b>Home Office Allocation</b>			
Heyl, Royster, Voelker, and Allen			-
GoffWilson			-
Jackson Lewis			-
Peter Gartelos			-
Miscellaneous Vendors			-
<b>Total Legal Fees</b>			<u><u>-</u></u>



Facility Name & ID Number Cisne Rehabilitation & Health Care Center# 0047423Report Period Beginning: 1/1/2010Ending: 12/31/2010**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. 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? N/A
- (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. \$ 7,561 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? No  
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. \$ 19,163  
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? N/A 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. \$ 5,244
- (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? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 46  
c. What percent of all travel expense relates to transportation of nurses and patients? 100  
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? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
**g. Does the facility transport residents to and from day training? N/A**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Ginoli & Company
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.