

Facility Name & ID Number Whispering Oaks

0050625 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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total
		3 Medicaid Recipient	4 Private Pay	Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	3,334			3,334	13
14	TOTALS	3,334			3,334	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 57.09%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

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

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

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

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

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

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

Medicare Intermediary N/A

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 Whispering Oaks # 0050625 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
	A. General Services										
1	Dietary	24,116	2,614	135	26,865		26,865	621	27,486		1
2	Food Purchase		14,533		14,533		14,533		14,533		2
3	Housekeeping	14,568	2,652		17,220		17,220	7	17,227		3
4	Laundry		5,225		5,225		5,225		5,225		4
5	Heat and Other Utilities			14,575	14,575		14,575	62	14,637		5
6	Maintenance		1,805	2,644	4,449		4,449	361	4,810		6
7	Other (specify):* <u>Home Off. Ben. All.</u>							146	146		7
8	TOTAL General Services	38,684	26,829	17,354	82,867		82,867	1,197	84,064		8
	B. Health Care and Programs										
9	Medical Director			900	900		900		900		9
10	Nursing and Medical Records	134,486	6,018	590	141,094		141,094	9	141,103		10
10a	Therapy										10a
11	Activities	9,456	349	308	10,113		10,113		10,113		11
12	Social Services	10,238	86		10,324		10,324		10,324		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Off. Ben. All.</u>										15
16	TOTAL Health Care and Programs	154,180	6,453	1,798	162,431		162,431	9	162,440		16
	C. General Administration										
17	Administrative			73,000	73,000		73,000	(32,223)	40,777		17
18	Directors Fees										18
19	Professional Services			480	480		480	874	1,354		19
20	Dues, Fees, Subscriptions & Promotions			1,112	1,112		1,112	306	1,418		20
21	Clerical & General Office Expenses		531	2,898	3,429		3,429	6,255	9,684		21
22	Employee Benefits & Payroll Taxes			26,434	26,434		26,434	594	27,028		22
23	Inservice Training & Education			84	84		84	44	128		23
24	Travel and Seminar							5	5		24
25	Other Admin. Staff Transportation			1,310	1,310		1,310	556	1,866		25
26	Insurance-Prop.Liab.Malpractice			6,260	6,260		6,260	92	6,352		26
27	Other (specify):* <u>Home Off. Ben. All.</u>							2,522	2,522		27
28	TOTAL General Administration		531	111,578	112,109		112,109	(20,975)	91,134		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	192,864	33,813	130,730	357,407		357,407	(19,769)	337,638		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number

Whispering Oaks

#0050625

Report Period Beginning:

1/1/2010

Ending:

12/31/2010

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			35,348	35,348		35,348	(3,094)	32,254			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			28,799	28,799		28,799	3,933	32,732			32
33	Real Estate Taxes			5,129	5,129		5,129	(57)	5,072			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			1,009	1,009		1,009	85	1,094			35
36	Other (specify):*											36
37	TOTAL Ownership			70,285	70,285		70,285	867	71,152			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			20,518	20,518		20,518		20,518			42
43	Other (specify):* Non-allowable Cost			12,910	12,910		12,910	(12,910)				43
44	TOTAL Special Cost Centers			33,428	33,428		33,428	(12,910)	20,518			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	192,864	33,813	234,443	461,120		461,120	(31,812)	429,308			45

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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(1,146)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(3,809)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(13,000)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	1,481	43		24
25	Fund Raising, Advertising and Promotional	(245)	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	(145)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (16,864)	Various	\$	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)	(14,948)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (14,948)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (31,812)		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		X		45
46	Other-Attach Schedule		X		46
47	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY							
48		49		50		51	52

Whispering Oaks

ID# 0050625

Report Period Beginning: 1/1/2010

Ending: 12/31/2010

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Disallow Real Estate Tax penalty	(145)	33	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
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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	(145)		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:	
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)	
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 621	\$ 621	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	0		2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	7	7	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	62	62	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	361	361	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	146	146	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	9	9	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	73,000	Petersen Health Care, Inc.	100.00%	40,777	(32,223)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	688	688	12
13	V							13
14	Total		\$ 73,000			\$ 42,671	\$ * (30,329)	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%	\$ 170	\$	170	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	6,181		6,181	16
17	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	44		44	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	5		5	18
19	V	25 Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	556		556	19
20	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	92		92	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	2,522		2,522	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	715		715	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	824		824	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	88		88	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%	85		85	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		\$			\$ 11,282	\$ *	11,282	39

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

Facility Name & ID Number

Whispering Oaks

0050625

Report Period Beginning:

1/1/2010

Ending: 12/31/2010

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 Network, LLC	100.00%	\$ 0	\$	15	
16	V	2 Food		Petersen Health Network, LLC	100.00%	0		16	
17	V	3 Housekeeping		Petersen Health Network, LLC	100.00%	0		17	
18	V	4 Laundry		Petersen Health Network, LLC	100.00%	0		18	
19	V	5 Utilities		Petersen Health Network, LLC	100.00%	0		19	
20	V	6 Maintenance		Petersen Health Network, LLC	100.00%	0		20	
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Network, LLC	100.00%	0		21	
22	V	10 Nursing and Medical Records		Petersen Health Network, LLC	100.00%	0		22	
23	V	10A Therapy		Petersen Health Network, LLC	100.00%	0		23	
24	V	15 Mgmt. Allocation of Benefits		Petersen Health Network, LLC	100.00%	0		24	
25	V	17 Administrative		Petersen Health Network, LLC	100.00%	0		25	
26	V	19 Professional Services		Petersen Health Network, LLC	100.00%	186	186	26	
27	V	20 Dues, Fees, Subs & Promotions		Petersen Health Network, LLC	100.00%	136	136	27	
28	V	21 Clerical and General Office		Petersen Health Network, LLC	100.00%	74	74	28	
29	V	22 Employee Benefits & Payroll		Petersen Health Network, LLC	100.00%	594	594	29	
30	V	24 Travel and Seminar		Petersen Health Network, LLC	100.00%	0		30	
31	V	25 Other Admin. Staff Transport.		Petersen Health Network, LLC	100.00%	0		31	
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Network, LLC	100.00%	0		32	
33	V	27 Mgmt. Allocation of Benefits		Petersen Health Network, LLC	100.00%	0		33	
34	V	30 Depreciation		Petersen Health Network, LLC	100.00%	0		34	
35	V	32 Interest		Petersen Health Network, LLC	100.00%	3,109	3,109	35	
36	V	33 Real Estate Taxes		Petersen Health Network, LLC	100.00%			36	
37	V	34 Rent-Facility and Grounds		Petersen Health Network, LLC	100.00%	0		37	
38	V	35 Rent-Equipment & Vehicles		Petersen Health Network, LLC	100.00%	0		38	
39	Total		\$			\$ 4,099	\$ *	4,099	39

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

Facility Name & ID Number

Whispering Oaks

0050625

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	181,826	0.13	0.21	Salary	\$ 424	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	\$ 424		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Whispering Oaks

0050625

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	3,334	\$ 621	1
2	2	Food	Resident Days	1,527,029	77	0	0	3,334	0	2
3	3	Housekeeping	Resident Days	1,527,029	77	3,369	0	3,334	7	3
4	4	Laundry	Resident Days	1,527,029	77	0	0	3,334	0	4
5	5	Utilities	Resident Days	1,527,029	77	28,267	0	3,334	62	5
6	6	Maintenance	Resident Days	1,527,029	77	165,545	121,901	3,334	361	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,527,029	77	66,650	0	3,334	146	7
8	10	Nursing and Medical Records	Resident Days	1,527,029	77	4,339	0	3,334	9	8
9	10A	Therapy	Resident Days	1,527,029	77	0	0	3,334	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,527,029	77	0	0	3,334	0	10
11	17	Administrative	Resident Days	1,527,029	77	5,157,152	5,157,152	3,334	40,777	11
12	19	Professional Services	Resident Days	1,527,029	77	315,156	0	3,334	688	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,527,029	77	78,050	0	3,334	170	13
14	21	Clerical and General Office	Resident Days	1,527,029	77	2,830,968	2,420,380	3,334	6,181	14
15	23	Inservice Training & Education	Resident Days	1,527,029	77	20,336	0	3,334	44	15
16	24	Travel and Seminar	Resident Days	1,527,029	77	2,344	0	3,334	5	16
17	25	Other Admin. Staff Transport.	Resident Days	1,527,029	77	254,752	0	3,334	556	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,527,029	77	42,233	0	3,334	92	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,527,029	77	1,155,252	0	3,334	2,522	19
20	30	Depreciation	Resident Days	1,527,029	77	327,648	0	3,334	715	20
21	32	Interest	Resident Days	1,527,029	77	377,597	0	3,334	824	21
22	33	Real Estate Taxes	Resident Days	1,527,029	77	40,405	0	3,334	88	22
23	34	Rent-Facility and Grounds	Resident Days	1,527,029	77	0	0	3,334	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,527,029	77	39,061	0	3,334	85	24
25	TOTALS					\$ 11,193,551	\$ 7,982,443		\$ 53,953	25

Facility Name & ID Number Whispering Oaks# 0050625

Report Period Beginning:

1/1/2010Ending: 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 Network, LLC

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309) 691-8113

Fax Number

(309) 691-8622

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	196,542	12	\$	\$	3,334	\$	1
2	2	Food	Resident Days	196,542	12			3,334		2
3	3	Housekeeping	Resident Days	196,542	12			3,334		3
4	4	Laundry	Resident Days	196,542	12			3,334		4
5	5	Utilities	Resident Days	196,542	12			3,334		5
6	6	Maintenance	Resident Days	196,542	12			3,334		6
7	7	Mgmt. Allocation of Benefits	Resident Days	196,542	12			3,334		7
8	10	Nursing and Medical Records	Resident Days	196,542	12			3,334		8
9	10A	Therapy	Resident Days	196,542	12			3,334		9
10	15	Mgmt. Allocation of Benefits	Resident Days	196,542	12			3,334		10
11	17	Administrative	Resident Days	196,542	12	10,985		3,334	186	11
12	19	Professional Services	Resident Days	196,542	12	8,001		3,334	136	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	196,542	12	4,389		3,334	74	13
14	21	Clerical and General Office	Resident Days	196,542	12	35,000		3,334	594	14
15	22	Employee Benefits & Payroll	Resident Days	196,542	12			3,334		15
16	24	Travel and Seminar	Resident Days	196,542	12			3,334		16
17	25	Other Admin. Staff Transport.	Resident Days	196,542	12			3,334		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	196,542	12			3,334		18
19	27	Mgmt. Allocation of Benefits	Resident Days	196,542	12			3,334		19
20	30	Depreciation	Resident Days	196,542	12			3,334		20
21	32	Interest	Resident Days	196,542	12	183,276		3,334	3,109	21
22	33	Real Estate Taxes	Resident Days	196,542	12			3,334		22
23	34	Rent-Facility and Grounds	Resident Days	196,542	12			3,334		23
24	35	Rent-Equipment & Vehicles	Resident Days	196,542	12			3,334		24
25	TOTALS					\$ 241,651	\$		\$ 4,099	25

Facility Name & ID Number

Whispering Oaks

0050625

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			
A. Directly Facility Related																			
Long-Term																			
1	The Private Bank		X	Mortgage	Varies	11/1/09	413,015	\$ 405,395	10/31/2029	Varies	\$ 28,799	1							
2												2							
3												3							
4							Home Office Allocation-PHC				824	4							
5							Home Office Allocation-PHN				3,109	5							
Working Capital																			
6												6							
7												7							
8												8							
9	TOTAL Facility Related						\$ 413,015	\$ 405,395			\$ 32,732	9							
B. Non-Facility Related*																			
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$	14							
15	TOTALS (line 9+line14)						\$ 413,015	\$ 405,395			\$ 32,732	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 must accompany the cost report.			
1. Real Estate Tax accrual used on 2009 report.			\$	4,900	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		\$	4,844	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(56)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	5,040	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.				88	
TOTAL REFUND	\$	For	Tax Year.	(Attach a copy of the real estate tax appeal board's decision.)	
			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	5,072	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2005	<u>3,763</u>		8	
	2006	<u>4,256</u>		9	
	2007	<u>4,529</u>		10	
	2008	<u>4,733</u>		11	
	2009	<u>4,844</u>		12	
<u>Accrual based on prior year tax bill.</u>					
FOR BHF USE ONLY					
	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.

Facility Name & ID Number Whispering Oaks

0050625 Report Period Beginning:

1/1/2010 Ending:

12/31/2010

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (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>10,000</u>	<u>2006</u>	<u>\$ 10,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	10,000		\$ 10,000	3

Facility Name & ID Number Whispering Oaks

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	
FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	16	2006	530,000		25	21,200	21,200	95,242	4
5									5
6									6
7									7
8									8
Improvement Type**									
9	A/C Unit	2009	2,985		5	598	598	897	9
10	A/C Unit	2010	3,860		15	129	129	129	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	Building Booked			21,200			(21,200)		31
32	Building Improvement Booked			683			(683)		32
33									33
34	2010-Home Office Allocation-Building Improvements		1,603			38	38		34
35	2010-Home Office Allocation-Land Improvements		150			8	8		35
36									36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Whispering Oaks

0050625

Report Period Beginning:

1/1/2010

Ending:

12/31/2010

XI. OWNERSHIP COSTS (continued)

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

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

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

Facility Name & ID Number Whispering Oaks

0050625

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	\$ <u>68,052</u>	\$ <u>13,465</u>	\$ <u>9,612</u>	\$ (3,853)	5-10 yrs.	\$ <u>43,048</u>	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	<u>Home Office Allocation</u>			<u>669</u>	<u>669</u>			74
75	TOTALS	\$ <u>68,052</u>	\$ <u>13,465</u>	\$ <u>10,281</u>	\$ (3,184)		\$ <u>43,048</u>	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77	<u>N/A</u>									77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ <u>616,650</u>	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ <u>35,348</u>	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ <u>32,254</u>	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (3,094)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ <u>139,316</u>	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	<u>N/A</u>				88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	<u>N/A</u>	\$	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? _____

If NO, see instructions. YES NO

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

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

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

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ 1,094 Description: See Attached Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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.

Whispering Oaks
0050625
Period Beginning
Period End

1/1/2010
12/31/2010

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$	1,009
Home Office Allocation		85
		<u>1,094</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?</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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist	N/A	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Whispering Oaks# 0050625Report 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	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 577,004	\$ 577,004	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>N/A</u>)	30,877	30,877	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	4,177	4,177	6
7	Other Prepaid Expenses	1,616	1,616	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 613,674	\$ 613,674	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	10,000	10,000	13
14	Buildings, at Historical Cost	530,000	531,603	14
15	Leasehold Improvements, at Historical Cost	6,845	6,995	15
16	Equipment, at Historical Cost	68,052	68,052	16
17	Accumulated Depreciation (book methods)	(165,205)	(139,316)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 449,692	\$ 477,334	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,063,366	\$ 1,091,008	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 91,262	\$ 91,262	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	11,886	11,886	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,096	4,096	31
32	Accrued Real Estate Taxes(Sch.IX-B)	5,040	5,040	32
33	Accrued Interest Payable	2,579	2,579	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Payroll Withholdings</u>	3,115	3,115	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 117,978	\$ 117,978	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	405,395	405,395	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)	\$ 405,395	\$ 405,395	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 523,373	\$ 523,373	46
47	TOTAL EQUITY(page 18, line 24)	\$ 539,993	\$ 567,635	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,063,366	\$ 1,091,008	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 650,891	1
2	Restatements (describe):		2
3	Rounding	3	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 650,894	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(110,901)	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)	\$ (110,901)	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)	\$ 539,993	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Whispering Oaks# 0050625Report 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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 350,219	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 350,219	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 350,219	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	82,867	31
32	Health Care	162,431	32
33	General Administration	112,109	33
B. Capital Expense			
34	Ownership	70,285	34
C. Ancillary Expense			
35	Special Cost Centers	12,910	35
36	Provider Participation Fee	20,518	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 461,120	40
41	Income before Income Taxes (line 30 minus line 40)**	(110,901)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (110,901)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. Facility is part of larger entity.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Whispering Oaks

0050625

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			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	CNAs & Orderlies	11,564	12,172	99,820	8.20	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	737	917	9,456	10.31	10
11	Social Service Workers	1,095	1,095	10,238	9.35	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	2,480	2,480	24,116	9.72	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	1,779	1,779	14,568	8.19	18
19	Laundry					19
20	Administrator	2,120	2,120	40,353	19.03	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	4,210	4,210	34,666	8.23	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	23,985	24,773	\$ 233,217 *	\$ 9.41	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	2	\$ 135	1(3)	35
36	Medical Director	Monthly	900	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	590	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)	2	\$ 1,625		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

Whispering Oaks

0050625

Period Beginning 1/1/2010

Period End 12/31/2010

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		480

Home Office Allocation

Heyl, Royster, Voelker & Allen	Legal	1
Healthcare Resources International	Legal	8
Ginoli & Company	Accountants	308
Bank of America	Accountants	27
Miscellaneous Vendors	Computer Services	4
VisionShare	Computer Services	37
Advanced Answers on Demand	Computer Services	230
Access 2 Go	Computer Services	37
Kemper Technology	Computer Services	32
MediFax	Computer Services	13
LogmeIn	Computer Services	9
Simple LTC	Computer Services	147
Optimizer Systems	Other Professional I	5
Clifton Gunderson	Other Professional I	16
Total (agree to Schedule V, line 19, column 8)		<u>1,354</u>

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. 200 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? N/A
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 1,181 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. \$ 20,518
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? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
 - a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
 - b. Do you have a separate contract with the Department to provide medical transportation for residents? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 0
 - 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? 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.