FOR BHF USE

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2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

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

I. IDPH License ID Number: 0046045

Facility Name: Arcola Health Care Center

Address: 422 E. Fourth St., P.O. Box 70 (Number) Arcola (City) 61910 (Zip Code)

County: Douglas

Telephone Number: (217) 268-3022 **Fax #** (217) 268-4180

HFS ID Number:

Date of Initial License for Current Owners: 11/09/93

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Larry Templin **Telephone Number:** (309) 689-5869
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2010 to 12/31/2010 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed)
(Date)
(Type or Print Name) Mark B. Petersen
(Title) Chief Executive Officer

Paid Preparer
(Signed)
(Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

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

Facility Name & ID Number Arcola Health Care Center # 0046045 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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	50	Skilled (SNF)	50	18,250	1
2		Skilled Pediatric (SNF/PED)			2
3	50	Intermediate (ICF)	50	18,250	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	100	TOTALS	100	36,500	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			1,301	1,301	8
9	SNF/PED					9
10	ICF	24,932	2,778	98	27,808	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,932	2,778	1,399	29,109	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.75%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 11/9/1993

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/9/1993 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 50 and days of care provided 1,301

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

Is your fiscal year identical to your tax year? YES [X] 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 Arcola Health Care Center # 0046045 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	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	155,423	22,250		177,673		177,673	5,422	183,095			1
2	Food Purchase		144,969		144,969		144,969	(4,383)	140,586			2
3	Housekeeping	108,664	20,779		129,443		129,443	64	129,507			3
4	Laundry	49,022	8,674		57,696		57,696		57,696			4
5	Heat and Other Utilities			83,171	83,171		83,171	539	83,710			5
6	Maintenance	29,235	14,039	20,112	63,386		63,386	3,156	66,542			6
7	Other (specify):* Home Off. Ben. All.							1,271	1,271			7
8	TOTAL General Services	342,344	210,711	103,283	656,338		656,338	6,069	662,407			8
	B. Health Care and Programs											
9	Medical Director			34,800	34,800		34,800		34,800			9
10	Nursing and Medical Records	803,166	53,111	216,034	1,072,311		1,072,311	18	1,072,329			10
10a	Therapy			127,502	127,502		127,502		127,502			10a
11	Activities	49,115	436	43	49,594		49,594	(91)	49,503			11
12	Social Services	65,449			65,449		65,449		65,449			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Off. Ben. All.											15
16	TOTAL Health Care and Programs	917,730	53,547	378,379	1,349,656		1,349,656	(73)	1,349,583			16
	C. General Administration											
17	Administrative			82,000	82,000		82,000	(11,052)	70,948			17
18	Directors Fees											18
19	Professional Services			6,758	6,758		6,758	6,008	12,766			19
20	Dues, Fees, Subscriptions & Promotions			1,865	1,865		1,865	1,138	3,003			20
21	Clerical & General Office Expenses	13,334	6,941	11,161	31,436		31,436	53,899	85,335			21
22	Employee Benefits & Payroll Taxes			192,560	192,560		192,560		192,560			22
23	Inservice Training & Education			450	450		450	388	838			23
24	Travel and Seminar			(150)	(150)		(150)	45	(105)			24
25	Other Admin. Staff Transportation			6,008	6,008		6,008	4,856	10,864			25
26	Insurance-Prop.Liab.Malpractice			38,544	38,544		38,544	805	39,349			26
27	Other (specify):* Home Off. Ben. All.							22,022	22,022			27
28	TOTAL General Administration	13,334	6,941	339,196	359,471		359,471	78,109	437,580			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,273,408	271,199	820,858	2,365,465		2,365,465	84,105	2,449,570			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 Arcola Health Care Center #0046045 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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			43,174	43,174		43,174	19,781	62,955			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			145,233	145,233		145,233	4,445	149,678			32
33	Real Estate Taxes			19,964	19,964		19,964	(259)	19,705			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			3,409	3,409		3,409	745	4,154			35
36	Other (specify):*											36
37	TOTAL Ownership			211,780	211,780		211,780	24,712	236,492			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		53,146		53,146		53,146		53,146			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,750	54,750		54,750		54,750			42
43	Other (specify):* Non-allowable Cost		267	62,556	62,823		62,823	(62,823)				43
44	TOTAL Special Cost Centers		53,413	117,306	170,719		170,719	(62,823)	107,896			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,273,408	324,612	1,149,944	2,747,964		2,747,964	45,994	2,793,958			45

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

Facility Name & ID Number Arcola Health Care Center # 0046045 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,383)	2		4
5	Telephone, TV & Radio in Resident Rooms	(8,825)	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	13,535	30		9
10	Interest and Other Investment Income	(2,753)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(270)	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	(100)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(30,850)	43		24
25	Fund Raising, Advertising and Promotional	(1,929)	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	(22,450)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (58,025)		$	30

BHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	104,019	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 104,019		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 45,994		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Arcola Health Care Center

ID# 0046045

Report Period Beginning: 1/1/2010

Ending: 12/31/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs-Part A	$ (3,775)	43	1
2	X-Rays-Part A	(1,945)	43	2
3	Offset Vending Revenue	(15,132)	43	3
4	Offset Miscellaneous Office Supplies Revenue	(66)	21	4
5	Offset Miscellaneous Nursing Supplies Revenue	(65)	10	5
6	Resident Flowers	(62)	43	6
7	Offset Transportaion Revenue	(91)	11	7
8	Disallowed Special Events	65	43	8
9	Disallowed Dues	(350)	20	9
10	Disallowed Real Estate Tax Late Fees	(1,029)	33	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
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31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(22,450)		49

Facility Name & ID Number Arcola Health Care Center # 0046045 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	$	Petersen Health Care, Inc.	100.00%	$ 5,422	$ 5,422	1
2	V	2	Food		Petersen Health Care, Inc.	100.00%	0		2
3	V	3	Housekeeping		Petersen Health Care, Inc.	100.00%	64	64	3
4	V	4	Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5	Utilities		Petersen Health Care, Inc.	100.00%	539	539	5
6	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	3,156	3,156	6
7	V	7	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,271	1,271	7
8	V	10	Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	83	83	8
9	V	11	Activities		Petersen Health Care, Inc.	100.00%	0		9
10	V	15	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		10
11	V	17	Administrative	82,000	Petersen Health Care, Inc.	100.00%	70,948	(11,052)	11
12	V	19	Professional Services		Petersen Health Care, Inc.	100.00%	6,008	6,008	12
13	V								13
14	Total			$ 82,000			$ 87,491	$ * 5,491	14

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

Facility Name & ID Number Arcola Health Care Center # 0046045 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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	20	Dues, Fees, Subs and Promotions	$	Petersen Health Care, Inc.	100.00%	$ 1,488	$ 1,488	15
16	V	21	Clerical and General Office		Petersen Health Care, Inc.	100.00%	53,965	53,965	16
17	V	23	Inservice Training and Education		Petersen Health Care, Inc.	100.00%	388	388	17
18	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	45	45	18
19	V	25	Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	4,856	4,856	19
20	V	26	Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	805	805	20
21	V	27	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	22,022	22,022	21
22	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	6,246	6,246	22
23	V	32	Interest		Petersen Health Care, Inc.	100.00%	7,198	7,198	23
24	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	770	770	24
25	V	34	Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0		25
26	V	35	Rent-Equipment and Vehicles		Petersen Health Care, Inc.	100.00%	745	745	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			$			$ 98,528	$ * 98,528	39

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

Facility Name & ID Number Arcola Health Care Center # 0046045 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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Petersen	President	Administrative	100.00	178,552	1.11	1.85	Salary	$ 3,698	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	$ 3,698		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 Arcola Health Care Center # 0046045 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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	1,527,029	77	$ 284,427	$ 283,010	29,109	$ 5,422	1
2	2	Food	Resident Days	1,527,029	77	0	0	29,109	0	2
3	3	Housekeeping	Resident Days	1,527,029	77	3,369	0	29,109	64	3
4	4	Laundry	Resident Days	1,527,029	77	0	0	29,109	0	4
5	5	Utilities	Resident Days	1,527,029	77	28,267	0	29,109	539	5
6	6	Maintenance	Resident Days	1,527,029	77	165,545	121,901	29,109	3,156	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,527,029	77	66,650	0	29,109	1,271	7
8	10	Nursing and Medical Records	Resident Days	1,527,029	77	4,339	0	29,109	83	8
9	10A	Therapy	Resident Days	1,527,029	77	0	0	29,109	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,527,029	77	0	0	29,109	0	10
11	17	Administrative	Resident Days	1,527,029	77	5,157,152	5,157,152	29,109	70,948	11
12	19	Professional Services	Resident Days	1,527,029	77	315,156	0	29,109	6,008	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,527,029	77	78,050	0	29,109	1,488	13
14	21	Clerical and General Office	Resident Days	1,527,029	77	2,830,968	2,420,380	29,109	53,965	14
15	23	Inservice Training & Education	Resident Days	1,527,029	77	20,336	0	29,109	388	15
16	24	Travel and Seminar	Resident Days	1,527,029	77	2,344	0	29,109	45	16
17	25	Other Admin. Staff Transport.	Resident Days	1,527,029	77	254,752	0	29,109	4,856	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,527,029	77	42,233	0	29,109	805	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,527,029	77	1,155,252	0	29,109	22,022	19
20	30	Depreciation	Resident Days	1,527,029	77	327,648	0	29,109	6,246	20
21	32	Interest	Resident Days	1,527,029	77	377,597	0	29,109	7,198	21
22	33	Real Estate Taxes	Resident Days	1,527,029	77	40,405	0	29,109	770	22
23	34	Rent-Facility and Grounds	Resident Days	1,527,029	77	0	0	29,109	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,527,029	77	39,061	0	29,109	745	24
25	TOTALS					$ 11,193,551	$ 7,982,443		$ 186,019	25

Facility Name & ID Number Arcola Health Care Center # 0046045 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	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Bank of America		X	Mortgage	$3,244 + int.	1/17/07	$ 2,775,000	$ 2,621,745	12/31/13	0.0832	$ 145,233	1
2												2
3							Interest Income Offset				(2,753)	3
4							Home Office Allocation-PHC				7,198	4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 2,775,000	$ 2,621,745			$ 149,678	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,775,000	$ 2,621,745			$ 149,678	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ **None** Line # **N/A**

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Arcola Health Care Center # 0046045 **Report Period Beginning:** 1/1/2010 **Ending:** 12/31/2010

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**		$ 26,600	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	$ 22,410	2
3. Under or (over) accrual (line 2 minus line 1).		$ (4,190)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 23,125	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **Home Office Allocation** 770 **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.		$ 19,705	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005	27,991	8
2006	26,064	9
2007	24,661	10
2008	25,853	11
2009	22,410	12

Accrual based on prior year tax bill.

	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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Arcola Health Care Center COUNTY Douglas

FACILITY IDPH LICENSE NUMBER 0046045

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

TELEPHONE (309)691-8113 FAX #: (309) 691-8622

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

Enter the tax index number and real estate tax assessed for 2009 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	01-14-09-200-00580	Long-Term Care Facility	$ 22,109.88	$ 22,109.88
2.	01-14-09-200-005	Long-Term Care Facility	$ 300.20	$ 300.20
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 22,410.08	$ 22,410.08

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number Arcola Health Care Center # 0046045 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 22,000 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

N/A

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	159,865	1993	$ 44,078	1
2					2
3	TOTALS	159,865		$ 44,078	3

Facility Name & ID Number Arcola Health Care Center # 0046045 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 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	100		1995	1975	$ 859,153	$	35	$ 24,547	$ 24,547	$ 380,478	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvement			1993	13,499		20	675	675	11,812	9
10	Building Improvement			1994	31,000		20	1,550	1,550	25,525	10
11	Building Improvement			1995	10,602		20	530	530	8,460	11
12	Landscaping			1997	5,593		20	280	280	3,779	12
13	Parking Lot			1997	6,500		20	325	325	4,388	13
14	Carpeting			1997	934		20	47	47	633	14
15	Door Closer			1997	1,225		20	61	61	825	15
16	Driveway Grading			1998	784		15	52	52	651	16
17	Guttering			1998	1,273		15	85	85	1,062	17
18	Wiring			1998	6,426		20	321	321	4,014	18
19	Windows			1998	2,330		15	155	155	1,939	19
20	Siding			1998	12,606		20	630	630	7,876	20
21	Doors			1998	765		15	51	51	638	21
22	Sink			1998	901		20	45	45	765	22
23	Garage			1998	8,286		15	552	552	6,901	23
24	Wood Flooring			1999	1,174		20	59	59	677	24
25	Asphalt Lot			1999	4,680		20	234	234	2,691	25
26	Tile			1999	6,477		20	324	324	3,724	26
27	Vinyl Siding			1999	5,600		25	224	224	2,576	27
28	Door Alarms			2000	1,593		20	80	80	839	28
29	Water Heater			2000	5,075		20	254	254	2,667	29
30	Sidewalk			2000	876		20	44	44	462	30
31	Carpeting			2000	670		20	34	34	356	31
32	Scarf Swags/Valances			2001	6,043		20	302	302	2,718	32
33	Scarf Holders			2001	1,083		20	54	54	486	33
34	Fence			2001	2,000		20	100	100	900	34
35	Replacement Wall			2001	686		20	34	34	307	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 Arcola Health Care Center # 0046045 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 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Security System	2002	$ 5,959	$	20	$ 298	$ 298	$ 2,533	37
38	Sprinkler System	2002	4,946		20	247	247	2,102	38
39	Sign	2002	1,248		20	62	62	916	39
40	Medicare Wing Expansion	2003	100,808		20	5,040	5,040	37,801	40
41	Architect Fees	2003	1,343		20	67	67	536	41
42	Patio	2003	5,858		20	293	293	2,344	42
43	Medicare Wing Expansion	2003	2,500		20	125	125	938	43
44	Medicare Wing Expansion	2003	750		20	38	38	283	44
45	Medicare Wing Expansion	2003	1,500		20	75	75	563	45
46	Medicare Wing Expansion	2003	500		20	25	25	188	46
47	Furnace	2004	2,195		20	110	110	715	47
48	Roofing	2005	2,500		20	125	125	689	48
49	Asphalt West Lot	2006	21,480		20	1,074	1,074	4,833	49
50	Door Alarm	2007	2,117		10	212	212	742	50
51	Furnace/Air Conditioner	2007	3,985		10	399	399	1,396	51
52	Blinds	2007	4,431		10	443	443	1,551	52
53	Windows	2007	19,021		20	951	951	3,329	53
54	Water Heater	2008	6,500		7	928	928	2,320	54
55	Boiler	2008	3,425		20	172	172	430	55
56	6 New Sprinklers	2008	5,990		25	240	240	600	56
57	Fire Alarm Repair	2008	2,899		7	414	414	1,035	57
58	Kitchen Exhaust Fan	2010	8,000		10	400	400	400	58
59									59
60									60
61									61
62	Land Improvements Booked			1,871			(1,871)		62
63	Building Booked			23,372			(23,372)		63
64	Building Improvement Booked			10,088			(10,088)		64
65									65
66	2010-Home Office Allocation-Building Improvements		13,992			336	336		66
67	2010-Home Office Allocation-Land Improvements		1,306			73	73		67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,221,087	$ 35,331		$ 43,796	$ 8,465	$ 544,393	70

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

Facility Name & ID Number Arcola Health Care Center # 0046045 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	$ 129,133	$ 6,918	$ 12,913	$ 5,995	10 yrs.	$ 106,093	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	128,973					128,973	73
74	Home Office Allocation			6,246	6,246			74
75	TOTALS	$ 258,106	$ 6,918	$ 19,159	$ 12,241		$ 235,066	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	1994 Dodge Van	1998	$ 28,010	$ 925	$	$ (925)	5	$ 28,010	76
77	Facility	2005 Ford	2004	33,217				5	33,217	77
78										78
79										79
80	TOTALS			$ 61,227	$ 925	$	$ (925)		$ 61,227	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)	$ 1,584,498	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 43,174	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 62,955	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 19,781	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 840,686	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.

Facility Name & ID Number Arcola Health Care Center # 0046045 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

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

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

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

	Fiscal Year Ending	Annual Rent
12.	/2011	$
13.	/2012	$
14.	/2013	$

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: $ 4,154 Description: See Attached Schedule 14A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Arcola Health Care Center
0046045
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	$	(299)
Dishwasher		708
Copier		3,000
Home Office Allocation		745
		4,154

Facility Name & ID Number Arcola Health Care Center # 0046045 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

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.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Arcola Health Care Center # 0046045 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A(3)	hrs	$	2,798	$ 41,974	$	2,798	$ 41,974	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2,456	36,838		2,456	36,838	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		3,246	48,690		3,246	48,690	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 prescrpts				53,146		53,146	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			$	8,500	$ 127,502	$ 53,146	8,500	$ 180,648	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.

STATE OF ILLINOIS

Facility Name & ID Number Arcola Health Care Center # 0046045 Report Period Beginning: 1/1/2010 Ending: 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*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,239,446	$ 2,239,446	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 6,000)	76,344	76,344	3
4	Supply Inventory (priced at Cost)			4
5	Short-Term Investments			5
6	Prepaid Insurance	26,105	26,105	6
7	Other Prepaid Expenses	12,222	12,222	7
8	Accounts Receivable (owners or related parties)	2,608,147	2,608,147	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,962,264	$ 4,962,264	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		44,078	13
14	Buildings, at Historical Cost	941,489	873,145	14
15	Leasehold Improvements, at Historical Cost	256,056	347,942	15
16	Equipment, at Historical Cost	338,206	319,333	16
17	Accumulated Depreciation (book methods)	(767,478)	(840,686)	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)**	$ 768,273	$ 743,812	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,730,537	$ 5,706,076	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 499,420	$ 499,420	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	77,901	77,901	30
31	Accrued Taxes Payable (excluding real estate taxes)	14,099	14,099	31
32	Accrued Real Estate Taxes(Sch.IX-B)	23,125	23,125	32
33	Accrued Interest Payable	12,773	12,773	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	35,123	35,123	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 662,441	$ 662,441	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,621,745	2,621,745	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,621,745	$ 2,621,745	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,284,186	$ 3,284,186	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,446,351	$ 2,421,890	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,730,537	$ 5,706,076	48

*(See instructions.)

Facility Name & ID Number Arcola Health Care Center **#** 0046045 **Report Period Beginning:** 1/1/2010 **Ending:** 12/31/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,053,560	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,053,560	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	392,791	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)**	$ 392,791	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,446,351	24 *

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

Facility Name & ID Number Arcola Health Care Center # 0046045 Report Period Beginning: 1/1/2010 Ending: 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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,931,099	1
2	Discounts and Allowances for all Levels	(91,435)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,839,664	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	179,049	6
7	Oxygen	34	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 179,083	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	4,383	14
15	Telephone, Television and Radio	6,264	15
16	Rental of Facility Space		16
17	Sale of Drugs	86,466	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	4,507	20
21	Other Medical Services	1,651	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 103,271	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,753	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,753	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous & Transportation Revenue	222	28
28a	Vending Income	15,762	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 15,984	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,140,755	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	656,338	31
32	Health Care	1,349,656	32
33	General Administration	359,471	33
	B. Capital Expense		
34	Ownership	211,780	34
	C. Ancillary Expense		
35	Special Cost Centers	115,969	35
36	Provider Participation Fee	54,750	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,747,964	40
41	**Income before Income Taxes (line 30 minus line 40)****	392,791	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 392,791	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 Arcola Health Care Center # 0046045 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 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,965	2,125	$ 30,911	$ 14.55	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,196	3,299	97,632	29.59	3
4	Licensed Practical Nurses	10,980	11,321	209,689	18.52	4
5	CNAs & Orderlies	36,728	37,807	376,043	9.95	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	174	223	2,123	9.52	9
10	Activity Assistants	2,506	2,584	24,080	9.32	10
11	Social Service Workers	4,955	4,955	65,449	13.21	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	30,469	14.65	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,396	14,984	124,954	8.34	15
16	Dishwashers					16
17	Maintenance Workers	2,025	2,041	29,235	14.32	17
18	Housekeepers	12,442	13,073	108,664	8.31	18
19	Laundry	5,526	5,800	49,022	8.45	19
20	Administrator	2,080	2,080	67,250	32.33	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,309	1,309	13,334	10.19	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: Transportation	1,910	2,060	22,912	11.12	32
33	Other(specify) Care Plan Coord.	4,121	4,177	88,891	21.28	33
34	TOTAL (lines 1 - 33)	106,393	109,918	$ 1,340,658 *	$ 12.20	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	34,800	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,683	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)		$ 39,483		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	504	20,623	10(3)	50
51	Licensed Practical Nurses	5,772	138,131	10(3)	51
52	Certified Nurse Assistants/Aides	2,747	52,443	10(3)	52
53	TOTAL (lines 50 - 52)	9,023	$ 211,197		53

Facility Name & ID Number Arcola Health Care Center # 0046045 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Karla Schnieder	Administrator	0	$ 67,250
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 67,250

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 82,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 82,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
E-Health Data Solutions	Computer Services	$ 3,420
Consolidated Communications	Computer Services	338
Clifton Gunderson	Accounting Services	3,000
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 6,758

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 39,292
Unemployment Compensation Insurance	26,661
FICA Taxes	95,783
Employee Health Insurance	28,166
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	1,299
Employee Retirement	1,377
Life Insurance	(18)
TOTAL (agree to Schedule V, line 22, col.8)	$ 192,560

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

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	199
Health Care Worker Background Check	
(Indicate # of checks performed 70)	
Patient Background Checks	700
Miscellaneous Licenses & Permits	556
Miscellaneous Dues & Subscriptions	410
IHCA Dues	0
Home Office Allocation	1,488
Less: Public Relations Expense	(350)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 3,003

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	(150)
Home Office Allocation	45
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ (105)

* Attach copy of IMRF notifications

**See instructions.

Arcola Health Care Center
0046045
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)		6,758
Home Office Allocation		
Heyl, Royster, Voelker & Allen	Legal	6
Healthcare Resources International	Legal	74
Ginoli & Company	Accountants	1,062
Bank of America	Accountants	234
Miscellaneous Vendors	Computer Services	32
VisionShare	Computer Services	320
Advanced Answers on Demand	Computer Services	2,009
Access 2 Go	Computer Services	326
Kemper Technology	Computer Services	277
MediFax	Computer Services	115
Logmeln	Computer Services	82
Simple LTC	Computer Services	1,281
Optimizer Systems	Other Professional Fees	46
Clifton Gunderson	Other Professional Fees	144
Total (agree to Schedule V, line 19, column 8)		12,766

Facility Name & ID Number Arcola Health Care Center # 0046045 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4	N/A												
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Arcola Health Care Center # 0046045 **Report Period Beginning:** 1/1/2010 **Ending:** 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? No
If YES, give association name and amount. N/A

(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. $ 11,152 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. $ 54,750
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. $ 4,383

(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. $ 91
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.