FOR BHF USE

LL1

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: 0048447

Facility Name: Collinsville Rehabilitation & Health Care Center

Address: 614 North Summit (Number) Collinsville (City) 62234 (Zip Code)

County: Madison

Telephone Number: (618) 344-8476 **Fax #** (618) 344-8483

HFS ID Number:

Date of Initial License for Current Owners: 07/25/2006

Type of Ownership:

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

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 Collinsville Rehabilitation & Health Care Center # 0048447 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	100	Skilled (SNF)	100	36,500	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	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	16,639	2,598	1,493	20,730	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,639	2,598	1,493	20,730	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 56.79%

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 7/25/2006

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 7/25/2006 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 100 and days of care provided 1,358

Medicare Intermediary Wisconsin Physician 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 Collinsville Rehabilitation & Health Care Cer # 0048447 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	114,624	12,436	1,159	128,219		128,219	3,861	132,080			1
2	Food Purchase		103,852		103,852		103,852	(3,769)	100,083			2
3	Housekeeping	83,467	19,530		102,997		102,997	46	103,043			3
4	Laundry	46,979	12,293		59,272		59,272		59,272			4
5	Heat and Other Utilities			86,245	86,245		86,245	384	86,629			5
6	Maintenance	30,714	9,872	22,691	63,277		63,277	2,351	65,628			6
7	Other (specify):* Home Off. Ben. All.							905	905			7
8	TOTAL General Services	275,784	157,983	110,095	543,862		543,862	3,778	547,640			8
	B. Health Care and Programs											
9	Medical Director			14,400	14,400		14,400		14,400			9
10	Nursing and Medical Records	857,991	59,976	3,626	921,593		921,593	59	921,652			10
10a	Therapy		1,005	178,082	179,087		179,087		179,087			10a
11	Activities	42,025	236	(1,043)	41,218		41,218		41,218			11
12	Social Services	30,038			30,038		30,038		30,038			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Off. Ben. All.											15
16	TOTAL Health Care and Programs	930,054	61,217	195,065	1,186,336		1,186,336	59	1,186,395			16
	C. General Administration											
17	Administrative			160,000	160,000		160,000	(68,661)	91,339			17
18	Directors Fees											18
19	Professional Services			21,632	21,632		21,632	6,657	28,289			19
20	Dues, Fees, Subscriptions & Promotions			9,461	9,461		9,461	3,896	13,357			20
21	Clerical & General Office Expenses	22,076	5,314	13,512	40,902		40,902	41,608	82,510			21
22	Employee Benefits & Payroll Taxes			196,029	196,029		196,029	3,539	199,568			22
23	Inservice Training & Education							276	276			23
24	Travel and Seminar							32	32			24
25	Other Admin. Staff Transportation			15,840	15,840		15,840	3,458	19,298			25
26	Insurance-Prop.Liab.Malpractice			39,534	39,534		39,534	573	40,107			26
27	Other (specify):* Home Off. Ben. All.							15,683	15,683			27
28	TOTAL General Administration	22,076	5,314	456,008	483,398		483,398	7,061	490,459			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,227,914	224,514	761,168	2,213,596		2,213,596	10,898	2,224,494			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 Collinsville Rehabilitation & Health Care Center #0048447 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			104,277	104,277		104,277	(11,066)	93,211			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			118,709	118,709		118,709	23,959	142,668			32
33	Real Estate Taxes			34,905	34,905		34,905	(1,993)	32,912			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			17,707	17,707		17,707	530	18,237			35
36	Other (specify):*											36
37	**TOTAL Ownership**			275,598	275,598		275,598	11,430	287,028			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		68,506		68,506		68,506		68,506			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		327	26,806	27,133		27,133	(27,133)				43
44	**TOTAL Special Cost Centers**		68,833	81,556	150,389		150,389	(27,133)	123,256			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,227,914	293,347	1,118,322	2,639,583		2,639,583	(4,805)	2,634,778			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 Collinsville Rehabilitation & Health Care Center # 0048447 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 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,769)	2		4
5	Telephone, TV & Radio in Resident Rooms	(1,393)	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	(20,931)	30		9
10	Interest and Other Investment Income	(80)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(277)	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	(10,100)	43		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	(4,258)	43		24
25	Fund Raising, Advertising and Promotional	(3,619)	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	(10,996)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (55,523)		$	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)	50,718	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 50,718		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (4,805)		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

STATE OF ILLINOIS

Collinsville Rehabilitation & Health Care Center

ID# 0048447

Report Period Beginning: 1/1/2010

Ending: 12/31/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs-Part A	$ (2,758)	43	1
2	X-Rays-Part A	(2,875)	43	2
3	Disallowed Real Estate Tax Late Fees	(2,541)	33	3
4	Offset Miscellaneous Office Supplies Revenue	(693)	21	4
5	Offset Chamber of Commerce Dues	(376)	20	5
6	Resident Flowers	(1,057)	43	6
7	Dislowed Special Events	(696)	43	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(10,996)		49

Facility Name & ID Number Collinsville Rehabilitation & Health Care Center # 0048447 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 Petersen	65	See Attached Schedule 6E		See Attached Sch. 6E		
Jifi Jacob	10					
Cindy White	10					
Jacque Whitley	10					
David Petersen	5					

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%	$ 3,861	$ 3,861	1
2	V	2	Food		Petersen Health Care, Inc.	100.00%	0		2
3	V	3	Housekeeping		Petersen Health Care, Inc.	100.00%	46	46	3
4	V	4	Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5	Utilities		Petersen Health Care, Inc.	100.00%	384	384	5
6	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	2,247	2,247	6
7	V	7	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	905	905	7
8	V	10	Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	59	59	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	160,000	Petersen Health Care, Inc.	100.00%	91,339	(68,661)	11
12	V	19	Professional Services		Petersen Health Care, Inc.	100.00%	4,278	4,278	12
13	V								13
14	Total			$ 160,000			$ 103,119	$ * (56,881)	14

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

Facility Name & ID Number Collinsville Rehabilitation & Health Care Center # 0048447 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%	$ 1,060	$ 1,060	15
16	V	21	Clerical and General Office		Petersen Health Care, Inc.	100.00%	38,431	38,431	16
17	V	23	Inservice Training and Education		Petersen Health Care, Inc.	100.00%	276	276	17
18	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	32	32	18
19	V	25	Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	3,458	3,458	19
20	V	26	Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	573	573	20
21	V	27	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	15,683	15,683	21
22	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	4,448	4,448	22
23	V	32	Interest		Petersen Health Care, Inc.	100.00%	5,126	5,126	23
24	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	548	548	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%	530	530	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			$			$ 70,165	$ * 70,165	39

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

Facility Name & ID Number Collinsville Rehabilitation & Health Care Center # 0048447 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	1	Dietary	$	Petersen Health Enterprises, LLC	100.00%	$	$	15
16	V	2	Food		Petersen Health Enterprises, LLC	100.00%			16
17	V	3	Housekeeping		Petersen Health Enterprises, LLC	100.00%			17
18	V	4	Laundry		Petersen Health Enterprises, LLC	100.00%			18
19	V	5	Utilities		Petersen Health Enterprises, LLC	100.00%			19
20	V	6	Maintenance		Petersen Health Enterprises, LLC	100.00%	104	104	20
21	V	7	Mgmt. Allocation of Benefits		Petersen Health Enterprises, LLC	100.00%	0		21
22	V	10	Nursing and Medical Records		Petersen Health Enterprises, LLC	100.00%	0		22
23	V	15	Mgmt. Allocation of Benefits		Petersen Health Enterprises, LLC	100.00%	0		23
24	V	17	Administrative		Petersen Health Enterprises, LLC	100.00%	0		24
25	V	19	Professional Services		Petersen Health Enterprises, LLC	100.00%	2,379	2,379	25
26	V	20	Dues, Fees, Subs & Promotions		Petersen Health Enterprises, LLC	100.00%	3,212	3,212	26
27	V	21	Clerical and General Office		Petersen Health Enterprises, LLC	100.00%	3,870	3,870	27
28	V	22	Employee Benefits & Payroll		Petersen Health Enterprises, LLC	100.00%	3,539	3,539	28
29	V	23	Inservice Training & Education		Petersen Health Enterprises, LLC	100.00%	0		29
30	V	24	Travel and Seminar		Petersen Health Enterprises, LLC	100.00%	0		30
31	V	25	Other Admin. Staff Transport.		Petersen Health Enterprises, LLC	100.00%	0		31
32	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Enterprises, LLC	100.00%	0		32
33	V	27	Mgmt. Allocation of Benefits		Petersen Health Enterprises, LLC	100.00%	0		33
34	V	30	Depreciation		Petersen Health Enterprises, LLC	100.00%	5,417	5,417	34
35	V	32	Interest		Petersen Health Enterprises, LLC	100.00%	18,913	18,913	35
36	V	33	Real Estate Taxes		Petersen Health Enterprises, LLC	100.00%	0		36
37	V	34	Rent-Facility and Grounds		Petersen Health Enterprises, LLC	100.00%	0		37
38	V	35	Rent-Equipment & Vehicles		Petersen Health Enterprises, LLC	100.00%	0		38
39	Total			$			$ 37,434	$ * 37,434	39

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

Facility Name & ID Number Collinsville Rehabilitation & Health Care Ce # 0048447 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	65.00	179,616	0.79	1.32	Salary	$ 2,634	L17, C7	1
2	Jifi Jacob	Owner	Administrative	10.00	0	55	100.00	Salary	85,500	L17, C7	2
3	Cindy S. White	Owner	Administrative	10.00	114,953	0.79	1.32	Salary	1,686	L21, C7	3
4	Jacque Whitley	Owner	Administrative	10.00	104,874	0.68	1.13	Salary	1,281	L21, C7	4
5											5
6											6
7											7
8											8
9											9
10		See Attached Schedule 7A									10
11											11
12											12
13								TOTAL	$ 91,101		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 Collinsville Rehabilitation & Health Care Center # 0048447 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	20,730	$ 3,861	1
2	2	Food	Resident Days	1,527,029	77	0	0	20,730	0	2
3	3	Housekeeping	Resident Days	1,527,029	77	3,369	0	20,730	46	3
4	4	Laundry	Resident Days	1,527,029	77	0	0	20,730	0	4
5	5	Utilities	Resident Days	1,527,029	77	28,267	0	20,730	384	5
6	6	Maintenance	Resident Days	1,527,029	77	165,545	121,901	20,730	2,247	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,527,029	77	66,650	0	20,730	905	7
8	10	Nursing and Medical Records	Resident Days	1,527,029	77	4,339	0	20,730	59	8
9	10A	Therapy	Resident Days	1,527,029	77	0	0	20,730	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,527,029	77	0	0	20,730	0	10
11	17	Administrative	Resident Days	1,527,029	77	5,157,152	5,157,152	20,730	91,339	11
12	19	Professional Services	Resident Days	1,527,029	77	315,156	0	20,730	4,278	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,527,029	77	78,050	0	20,730	1,060	13
14	21	Clerical and General Office	Resident Days	1,527,029	77	2,830,968	2,420,380	20,730	38,431	14
15	23	Inservice Training & Education	Resident Days	1,527,029	77	20,336	0	20,730	276	15
16	24	Travel and Seminar	Resident Days	1,527,029	77	2,344	0	20,730	32	16
17	25	Other Admin. Staff Transport.	Resident Days	1,527,029	77	254,752	0	20,730	3,458	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,527,029	77	42,233	0	20,730	573	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,527,029	77	1,155,252	0	20,730	15,683	19
20	30	Depreciation	Resident Days	1,527,029	77	327,648	0	20,730	4,448	20
21	32	Interest	Resident Days	1,527,029	77	377,597	0	20,730	5,126	21
22	33	Real Estate Taxes	Resident Days	1,527,029	77	40,405	0	20,730	548	22
23	34	Rent-Facility and Grounds	Resident Days	1,527,029	77	0	0	20,730	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,527,029	77	39,061	0	20,730	530	24
25	TOTALS					$ 11,193,551	$ 7,982,443		$ 173,284	25

Facility Name & ID Number Collinsville Rehabilitation & Health Care Center # 0048447 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 Enterprises, LLC
Street Address: 830 W. Trailcreek Drive
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 691-8113
Fax Number: (309) 691-8622

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	87,853	5	$	$	20,730	$	1
2	2	Food	Resident Days	87,853	5			20,730		2
3	3	Housekeeping	Resident Days	87,853	5			20,730		3
4	4	Laundry	Resident Days	87,853	5			20,730		4
5	5	Utilities	Resident Days	87,853	5			20,730		5
6	6	Maintenance	Resident Days	87,853	5	441		20,730	104	6
7	7	Mgmt. Allocation of Benefits	Resident Days	87,853	5			20,730		7
8	10	Nursing and Medical Records	Resident Days	87,853	5			20,730		8
9	15	Mgmt. Allocation of Benefits	Resident Days	87,853	5			20,730		9
10	17	Administrative	Resident Days	87,853	5			20,730		10
11	19	Professional Services	Resident Days	87,853	5	10,081		20,730	2,379	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	87,853	5	13,612		20,730	3,212	12
13	21	Clerical and General Office	Resident Days	87,853	5	16,401		20,730	3,870	13
14	22	Employee Benefits & Payroll	Resident Days	87,853	5	14,999		20,730	3,539	14
15	23	Inservice Training & Education	Resident Days	87,853	5			20,730		15
16	24	Travel and Seminar	Resident Days	87,853	5			20,730		16
17	25	Other Admin. Staff Transport.	Resident Days	87,853	5			20,730		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	87,853	5			20,730		18
19	27	Mgmt. Allocation of Benefits	Resident Days	87,853	5			20,730		19
20	30	Depreciation	Resident Days	87,853	5	22,959		20,730	5,417	20
21	32	Interest	Resident Days	87,853	5	80,152		20,730	18,913	21
22	33	Real Estate Taxes	Resident Days	87,853	5			20,730		22
23	34	Rent-Facility and Grounds	Resident Days	87,853	5			20,730		23
24	35	Rent-Equipment & Vehicles	Resident Days	87,853	5			20,730		24
25	TOTALS					$ 158,645	$		$ 37,434	25

Facility Name & ID Number Collinsville Rehabilitation & Health Care Cen # 0048447 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	F&M Bank		X	Mortgage	$15,260.00	12/8/08	$ 1,648,480	$ 1,515,675	12/8/11	0.0700	$ 109,928	1
2												2
3							Interest Income Offset				(80)	3
4							Home Office Allocation-PHC				5,126	4
5							Home Office Allocation-PHE				18,913	5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$15,260.00		$ 1,648,480	$ 1,515,675			$ 133,887	9
	B. Non-Facility Related*											
10							Amortization on Mortgage Costs				8,781	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 8,781	14
15	TOTALS (line 9+line14)						$ 1,648,480	$ 1,515,675			$ 142,668	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 Collinsville Rehabilitation & Health Care Center **#** 0048447 **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.**	$ 65,900	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	$ 48,404	2
3. Under or (over) accrual (line 2 minus line 1).		$ (17,496)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 49,860	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**	548	
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.		$ 32,912	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005		8
2006	62,716	9
2007	65,053	10
2008	67,174	11
2009	48,404	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 Collinsville Rehabilitation & Health Care Center COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0048447

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.	13-2-21-28-18-303-001	Long-Term Care Facility	$ 48,404.00	$ 48,404.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 48,404.00	$ 48,404.00

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 Collinsville Rehabilitation & Health Care Center # 0048447 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 29,350 B. General Construction Type: Exterior Brick Frame Steel 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	391,343	2006	$ 40,000	1
2					2
3	TOTALS	391,343		$ 40,000	3

Facility Name & ID Number Collinsville Rehabilitation & Health Care Center # 0048447 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		2006	1962	$ 1,635,299	$	30	$ 54,510	$ 54,510	$ 245,295	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Wheelchair Ramp			2007	2,530		15	169	169	591	9
10	Fountain			2007	1,269		15	85	85	297	10
11	Exit Signs			2007	612		7	87	87	305	11
12	Blinds			2007	4,886		10	489	489	1,711	12
13	Exit Signs			2008	690		15	46	46	115	13
14	Boiler			2009	6,500		7	464	464	928	14
15	Sprinkler Repair			2009	22,880		7	3,268	3,268	4,902	15
16	Boiler			2010	11,339		15	378	378	378	16
17	A/C Unit			2010	6,260		15	209	209	209	17
18	Roof Replacement			2010	69,464		25	1,389	1,389	1,389	18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30	Land Improvements Booked					254			(254)		30
31	Building Booked					65,653			(65,653)		31
32	Building Improvement Booked					5,892			(5,892)		32
33											33
34	2010-Home Office Allocation-Building Improvements				9,964			239	239		34
35	2010-Home Office Allocation-Land Improvements				930			52	52		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 Collinsville Rehabilitation & Health Care Center # 0048447 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			$	$		$	$	$	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)		$ 1,772,623	$ 71,799		$ 61,385	$ (10,414)	$ 256,120	70

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

Facility Name & ID Number Collinsville Rehabilitation & Health Care Center # 0048447 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	$ 215,799	$ 31,909	$ 21,581	$ (10,328)	10 yrs.	$ 91,696	71
72	Current Year Purchases	7,594	569	380	(189)	10 yrs.	380	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			9,865	9,865			74
75	TOTALS	$ 223,393	$ 32,478	$ 31,826	$ (652)		$ 92,076	75

D. Vehicle Depreciation (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,036,016	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 104,277	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 93,211	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (11,066)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 348,196	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 Collinsville Rehabilitation & Health Care Center # 0048447 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:				$ N/A			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 ☒ X NO

16. Rental Amount for movable equipment: $ 11,775 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	Facility	2009 Ford E150	$ 538.00	$ 6,462	17
18					18
19					19
20					20
21	TOTAL		$ 538.00	$ 6,462	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.

Collinsville Rehabilitation & Health Care Center
0048447
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	$	7,128
Dishwasher		708
Copier		3,409
Home Office Allocation		530
		11,775

Facility Name & ID Number Collinsville Rehabilitation & Health Care Center # 0048447 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 Collinsville Rehabilitation & Health Care Center # 0048447 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		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	10A(3)	hrs	$	4,545	$ 68,170	$	4,545	$ 68,170	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2,170	32,546		2,170	32,546	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		5,143	77,146	1,005	5,143	78,151	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				68,506		68,506	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Respiratory Therapy	10A(3)			15	220		15	220	13
14	TOTAL			$	11,873	$ 178,082	$ 69,511	11,873	$ 247,593	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 Collinsville Rehabilitation & Health Care Center # 0048447 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	$ (249,878)	$ (249,878)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 30,000)	342,270	342,270	3
4	Supply Inventory (priced at Cost)			4
5	Short-Term Investments			5
6	Prepaid Insurance	26,963	26,963	6
7	Other Prepaid Expenses	10,390	10,390	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Security Deposit	243	243	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 129,988	$ 129,988	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	43,799	40,000	13
14	Buildings, at Historical Cost	1,635,299	1,645,263	14
15	Leasehold Improvements, at Historical Cost	117,746	127,360	15
16	Equipment, at Historical Cost	228,278	223,393	16
17	Accumulated Depreciation (book methods)	(429,229)	(348,196)	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 (spe Loan Costs	8,050	8,050	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,603,943	$ 1,695,870	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,733,931	$ 1,825,858	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 448,704	$ 448,704	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	76,358	76,358	30
31	Accrued Taxes Payable (excluding real estate taxes)	13,716	13,716	31
32	Accrued Real Estate Taxes(Sch.IX-B)	49,860	49,860	32
33	Accrued Interest Payable	9,147	9,147	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	32,065	32,065	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 629,850	$ 629,850	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,515,675	1,515,675	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,515,675	$ 1,515,675	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,145,525	$ 2,145,525	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (411,594)	$ (319,667)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,733,931	$ 1,825,858	48

*(See instructions.)

Facility Name & ID Number Collinsville Rehabilitation & Health Care Center **#** 0048447 **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**	$ (437,018)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (437,018)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	25,424	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)**	$ 25,424	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)**	$ (411,594)	24 *

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

Facility Name & ID Number Collinsville Rehabilitation & Health Care Center # 0048447 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	$ 2,387,758	1
2	Discounts and Allowances for all Levels	(113,199)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,274,559	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	264,437	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 264,437	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	3,769	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	111,917	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	5,073	20
21	Other Medical Services	4,479	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 125,238	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	80	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 80	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	693	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 693	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,665,007	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	543,862	31
32	Health Care	1,186,336	32
33	General Administration	483,398	33
	B. Capital Expense		
34	Ownership	275,598	34
	C. Ancillary Expense		
35	Special Cost Centers	95,639	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)***	$ 2,639,583	40
41	**Income before Income Taxes (line 30 minus line 40)****	25,424	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 25,424	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 Collinsville Rehabilitation & Health Care Center # 0048447 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	1,831	1,831	$ 46,470	$ 25.38	1
2	Assistant Director of Nursing	335	349	8,230	23.58	2
3	Registered Nurses	2,247	2,266	51,100	22.55	3
4	Licensed Practical Nurses	13,775	14,098	280,327	19.88	4
5	CNAs & Orderlies	39,572	41,058	422,212	10.28	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,818	1,969	24,091	12.24	9
10	Activity Assistants					10
11	Social Service Workers	2,080	2,080	30,038	14.44	11
12	Dietician					12
13	Food Service Supervisor	3,993	4,047	49,085	12.13	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,443	7,764	65,539	8.44	15
16	Dishwashers					16
17	Maintenance Workers	1,956	2,085	30,714	14.73	17
18	Housekeepers	6,704	6,927	83,467	12.05	18
19	Laundry	5,547	5,733	46,979	8.19	19
20	Administrator	2,247	2,247	88,705	39.48	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,554	1,649	22,076	13.39	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	2,264	2,334	17,934	7.68	32
33	Other(specify) CPC	2,080	2,080	49,652	23.87	33
34	TOTAL (lines 1 - 33)	95,446	98,517	$ 1,316,619 *	$ 13.36	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	Monthly	$ 1,159	1(3)	35
36	Medical Director	Monthly	14,400	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,256	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)		$ 18,815		49

C. CONTRACT NURSES

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

Facility Name & ID Number Collinsville Rehabilitation & Health Care Center # 0048447 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jifi Jacob	Administrator	0	$ 85,500
Beverly Goodman	Administrator	0	3,205
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 88,705

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 160,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 160,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
E-Health Data Solutions	Computer Services	$ 3,420
Windstream Communications	Computer Services	2,548
NuVox	Computer Services	29
Clifton Gunderson	Accounting Services	3,000
Heyl, Royster, Voelker & Allen	Legal Services	5,234
Brown & James	Legal Services	7,401
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 21,632

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 51,922
Unemployment Compensation Insurance	24,023
FICA Taxes	92,440
Employee Health Insurance	24,159
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	6,179
Employee Retirement	695
Life Insurance	150
TOTAL (agree to Schedule V, line 22, col.8)	$ 199,568

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

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	2,707
Health Care Worker Background Check	
(Indicate # of checks performed 166)	
Patient Background Checks	1,660
Miscellaneous Licenses & Permits	1,328
Miscellaneous Dues & Subscriptions	376
IHCA Dues	1,400
Home Office Allocation	4,272
Less: Public Relations Expense	(376)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,357

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Home Office Allocation	32
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 32

**See instructions.

Collinsville Rehabilitation & Health Care Center
0048447
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)		21,632
Home Office Allocation		
Heyl, Royster, Voelker & Allen	Legal	4
Healthcare Resources International	Legal	53
Ginoli & Company	Accountants	3,136
Bank of America	Accountants	166
Miscellaneous Vendors	Computer Services	23
VisionShare	Computer Services	228
Advanced Answers on Demand	Computer Services	1,431
Access 2 Go	Computer Services	232
Kemper Technology	Computer Services	197
MediFax	Computer Services	82
Logmeln	Computer Services	58
Simple LTC	Computer Services	912
Optimizer Systems	Other Professional Fees	33
Clifton Gunderson	Other Professional Fees	102
Total (agree to Schedule V, line 19, column 8)		28,289

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

Schedule 21B

XIX. SUPPORT SCHEDULE
Legal Fees

Facility

Vendor/Payee	Invoice Total	Allocation %	Total
Heyl, Royster, Voelker, and Allen	69.00	100%	69
Heyl, Royster, Voelker, and Allen	303.06	100%	303
Brown & James	3,698.16	100%	3,698
Heyl, Royster, Voelker, and Allen	256.19	100%	256
Heyl, Royster, Voelker, and Allen	348.20	100%	348
Brown & James	1,505.67	100%	1,506
Heyl, Royster, Voelker, and Allen	350.00	100%	350
Heyl, Royster, Voelker, and Allen	92.00	100%	92
Heyl, Royster, Voelker, and Allen	46.00	100%	46
Heyl, Royster, Voelker, and Allen	3,652.58	100%	3,653
Brown & James	2,196.79	100%	2,197
Heyl, Royster, Voelker, and Allen	117.57	100%	118
Home Office Allocation			
Heyl, Royster, Voelker & Allen			4
Healthcare Resources International			53
Total Legal Fees			12,692

Facility Name & ID Number Collinsville Rehabilitation & Health Care Center # 0048447 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 Collinsville Rehabilitation & Health Care Center # 0048447 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? **Yes**
If YES, give association name and amount. **1,400 IHCA**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 yrs.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **8,569** 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. $ **3,769**

(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? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.