

Facility Name & ID Number Enfield Rehabilitation & Health Care Center

0047464 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	49	Intermediate (ICF)	49	17,885	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	49	TOTALS	49	17,885	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total
		3 Medicaid Recipient	4 Private Pay	Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	9,220	679		9,899	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,220	679		9,899	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 55.35%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 10/1/05

J. Was the facility purchased or leased after January 1, 1978?
YES Date 10/1/05 NO

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

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number Enfield Rehabilitation & Health Care Center # 0047464 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	101,855	7,350	975	110,180		110,180	1,844	112,024		1
2	Food Purchase		61,631		61,631		61,631	(3,664)	57,967		2
3	Housekeeping	76,061	11,047		87,108		87,108	22	87,130		3
4	Laundry		4,289		4,289		4,289		4,289		4
5	Heat and Other Utilities			51,867	51,867		51,867	183	52,050		5
6	Maintenance	19,641	7,889	11,789	39,319		39,319	1,073	40,392		6
7	Other (specify):* <u>Home Off. Ben. All.</u>							432	432		7
8	TOTAL General Services	197,557	92,206	64,631	354,394		354,394	(110)	354,284		8
	B. Health Care and Programs										
9	Medical Director			4,200	4,200		4,200		4,200		9
10	Nursing and Medical Records	464,492	26,309	1,530	492,331		492,331	28	492,359		10
10a	Therapy										10a
11	Activities	19,776	125	78	19,979		19,979	(555)	19,424		11
12	Social Services	17,186	48		17,234		17,234		17,234		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Off. Ben. All.</u>										15
16	TOTAL Health Care and Programs	501,454	26,482	5,808	533,744		533,744	(527)	533,217		16
	C. General Administration										
17	Administrative			115,000	115,000		115,000	(54,456)	60,544		17
18	Directors Fees										18
19	Professional Services			9,162	9,162		9,162	2,479	11,641		19
20	Dues, Fees, Subscriptions & Promotions			1,852	1,852		1,852	926	2,778		20
21	Clerical & General Office Expenses		2,179	5,133	7,312		7,312	19,083	26,395		21
22	Employee Benefits & Payroll Taxes			92,006	92,006		92,006	1,597	93,603		22
23	Inservice Training & Education			600	600		600	132	732		23
24	Travel and Seminar							15	15		24
25	Other Admin. Staff Transportation			4,359	4,359		4,359	1,651	6,010		25
26	Insurance-Prop.Liab.Malpractice			18,978	18,978		18,978	274	19,252		26
27	Other (specify):* <u>Home Off. Ben. All.</u>							7,489	7,489		27
28	TOTAL General Administration		2,179	247,090	249,269		249,269	(20,810)	228,459		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	699,011	120,867	317,529	1,137,407		1,137,407	(21,447)	1,115,960		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 Enfield Rehabilitation & Health Care Center #0047464 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			24,058	24,058		24,058	2,801	26,859			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			9,717	9,717		9,717	13,254	22,971			32
33	Real Estate Taxes			6,038	6,038		6,038	23	6,061			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			14,903	14,903		14,903	253	15,156			35
36	Other (specify):*											36
37	TOTAL Ownership			54,716	54,716		54,716	16,331	71,047			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			26,828	26,828		26,828		26,828			42
43	Other (specify):* Non-allowable Cost		446	6,839	7,285		7,285	(7,285)				43
44	TOTAL Special Cost Centers		446	33,667	34,113		34,113	(7,285)	26,828			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	699,011	121,313	405,912	1,226,236		1,226,236	(12,401)	1,213,835			45

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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,664)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,928)	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	189	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(227)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(174)	43		24
25	Fund Raising, Advertising and Promotional	(2,896)	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	(1,945)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (11,645)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(756)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (756)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (12,401)		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

Enfield Rehabilitation & Health Care Center

ID# 0047464

Report Period Beginning: 1/1/2010

Ending: 12/31/2010

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Offset Miscellaneous Office Supplies Revenue	\$ (91)	21	1
2	Resident Flowers	(285)	43	2
3	Offset Transportation Revenue	(555)	11	3
4	Offset Cable TV Revenue	(775)	43	4
5	Disallow Real Estate Tax penalty	(239)	33	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
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42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,945)		49

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 1,844	\$ 1,844	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	0		2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	22	22	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	183	183	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	1,073	1,073	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	432	432	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	28	28	8
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		10
11	V	17 Administrative	115,000	Petersen Health Care, Inc.	100.00%	60,544	(54,456)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	2,043	2,043	12
13	V							13
14	Total		\$ 115,000			\$ 66,169	\$ * (48,831)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	20 Dues, Fees, Subs & Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 506	\$	506	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	18,352		18,352	16
17	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	132		132	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	15		15	18
19	V	25 Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	1,651		1,651	19
20	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	274		274	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	7,489		7,489	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	2,124		2,124	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	2,448		2,448	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	262		262	24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0			25
26	V	35 Rent-Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	253		253	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		\$			\$ 33,506	\$ *	33,506	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 Dietary	\$	Petersen Health Operations, LLC	100.00%	\$ 0	\$	15
16	V	2 Food		Petersen Health Operations, LLC	100.00%	0		16
17	V	3 Housekeeping		Petersen Health Operations, LLC	100.00%	0		17
18	V	4 Laundry		Petersen Health Operations, LLC	100.00%	0		18
19	V	5 Utilities		Petersen Health Operations, LLC	100.00%	0		19
20	V	6 Maintenance		Petersen Health Operations, LLC	100.00%	0		20
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	0		21
22	V	10 Nursing and Medical Records		Petersen Health Operations, LLC	100.00%	0		22
23	V	12 Social Services		Petersen Health Operations, LLC	100.00%	0		23
24	V	17 Administrative		Petersen Health Operations, LLC	100.00%	0		24
25	V	19 Professional Services		Petersen Health Operations, LLC	100.00%	436	436	25
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Operations, LLC	100.00%	420	420	26
27	V	21 Clerical and General Office		Petersen Health Operations, LLC	100.00%	822	822	27
28	V	22 Employee Benefits & Payroll		Petersen Health Operations, LLC	100.00%	1,597	1,597	28
29	V	23 Inservice Training & Education		Petersen Health Operations, LLC	100.00%	0		29
30	V	24 Travel and Seminar		Petersen Health Operations, LLC	100.00%	0		30
31	V	25 Other Admin. Staff Transport.		Petersen Health Operations, LLC	100.00%	0		31
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Operations, LLC	100.00%	0		32
33	V	27 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	0		33
34	V	30 Depreciation		Petersen Health Operations, LLC	100.00%	488	488	34
35	V	32 Interest		Petersen Health Operations, LLC	100.00%	10,806	10,806	35
36	V	33 Real Estate Taxes		Petersen Health Operations, LLC	100.00%	0		36
37	V	34 Rent-Facility and Grounds		Petersen Health Operations, LLC	100.00%	0		37
38	V	35 Rent-Equipment & Vehicles		Petersen Health Operations, LLC	100.00%	0		38
39	Total		\$			\$ 14,569	\$ *	14,569

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

Facility Name & ID Number Enfield Rehabilitation & Health Care Center # 0047464 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Petersen	President	Administrative	100.00	180,992	0.38	0.63	Salary	\$ 1,258	L17, C7	1
2											2
3											3
4											4
5		See Attached Schedule 7A									5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 1,258		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 Enfield Rehabilitation & Health Care Center

0047464

Report Period Beginning:

1/1/2010

Ending: 2/31/2010

VIII. ALLOCATION OF INDIRECT COSTS

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

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	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,527,029	77	\$ 284,427	\$ 283,010	9,899	\$ 1,844	1
2	2	Food	Resident Days	1,527,029	77	0	0	9,899	0	2
3	3	Housekeeping	Resident Days	1,527,029	77	3,369	0	9,899	22	3
4	4	Laundry	Resident Days	1,527,029	77	0	0	9,899	0	4
5	5	Utilities	Resident Days	1,527,029	77	28,267	0	9,899	183	5
6	6	Maintenance	Resident Days	1,527,029	77	165,545	121,901	9,899	1,073	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,527,029	77	66,650	0	9,899	432	7
8	10	Nursing and Medical Records	Resident Days	1,527,029	77	4,339	0	9,899	28	8
9	10A	Therapy	Resident Days	1,527,029	77	0	0	9,899	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,527,029	77	0	0	9,899	0	10
11	17	Administrative	Resident Days	1,527,029	77	5,157,152	5,157,152	9,899	60,544	11
12	19	Professional Services	Resident Days	1,527,029	77	315,156	0	9,899	2,043	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,527,029	77	78,050	0	9,899	506	13
14	21	Clerical and General Office	Resident Days	1,527,029	77	2,830,968	2,420,380	9,899	18,352	14
15	23	Inservice Training & Education	Resident Days	1,527,029	77	20,336	0	9,899	132	15
16	24	Travel and Seminar	Resident Days	1,527,029	77	2,344	0	9,899	15	16
17	25	Other Admin. Staff Transport.	Resident Days	1,527,029	77	254,752	0	9,899	1,651	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,527,029	77	42,233	0	9,899	274	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,527,029	77	1,155,252	0	9,899	7,489	19
20	30	Depreciation	Resident Days	1,527,029	77	327,648	0	9,899	2,124	20
21	32	Interest	Resident Days	1,527,029	77	377,597	0	9,899	2,448	21
22	33	Real Estate Taxes	Resident Days	1,527,029	77	40,405	0	9,899	262	22
23	34	Rent-Facility and Grounds	Resident Days	1,527,029	77	0	0	9,899	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,527,029	77	39,061	0	9,899	253	24
25	TOTALS					\$ 11,193,551	\$ 7,982,443		\$ 99,675	25

Facility Name & ID Number Enfield Rehabilitation & Health Care Center

0047464

Report Period Beginning:

1/1/2010

Ending: 2/31/2010

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	389,552	21	\$	\$ 9,899	\$	1
2	2	Food	Resident Days	389,552	21		9,899		2
3	3	Housekeeping	Resident Days	389,552	21		9,899		3
4	4	Laundry	Resident Days	389,552	21		9,899		4
5	5	Utilities	Resident Days	389,552	21		9,899		5
6	6	Maintenance	Resident Days	389,552	21		9,899		6
7	7	Mgmt. Allocation of Benefits	Resident Days	389,552	21		9,899		7
8	10	Nursing and Medical Records	Resident Days	389,552	21		9,899		8
9	12	Social Services	Resident Days	389,552	21		9,899		9
10	17	Administrative	Resident Days	389,552	21		9,899		10
11	19	Professional Services	Resident Days	389,552	21	17,164	9,899	436	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	389,552	21	16,534	9,899	420	12
13	21	Clerical and General Office	Resident Days	389,552	21	32,356	9,899	822	13
14	22	Employee Benefits & Payroll	Resident Days	389,552	21	62,830	9,899	1,597	14
15	23	Inservice Training & Education	Resident Days	389,552	21		9,899		15
16	24	Travel and Seminar	Resident Days	389,552	21		9,899		16
17	25	Other Admin. Staff Transport.	Resident Days	389,552	21		9,899		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	389,552	21		9,899		18
19	27	Mgmt. Allocation of Benefits	Resident Days	389,552	21		9,899		19
20	30	Depreciation	Resident Days	389,552	21	19,207	9,899	488	20
21	32	Interest	Resident Days	389,552	21	425,239	9,899	10,806	21
22	33	Real Estate Taxes	Resident Days	389,552	21		9,899		22
23	34	Rent-Facility and Grounds	Resident Days	389,552	21		9,899		23
24	35	Rent-Equipment & Vehicles	Resident Days	389,552	21		9,899		24
25	TOTALS					\$ 573,330	\$	\$ 14,569	25

Facility Name & ID Number Enfield Rehabilitation & Health Care Center # 0047464 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1	Bank of America		X	Mortgage	Varies	1/19/07	\$ 200,000	\$ 191,509	12/31/13	Varies	\$ 9,717	1							
2												2							
3												3							
4							Home Office Allocation-PHC				2,448	4							
5							Home Office Allocation-PHO				10,806	5							
Working Capital																			
6												6							
7												7							
8												8							
9	TOTAL Facility Related						\$ 200,000	\$ 191,509			\$ 22,971	9							
B. Non-Facility Related*																			
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$	14							
15	TOTALS (line 9+line14)						\$ 200,000	\$ 191,509			\$ 22,971	15							

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

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1. Real Estate Tax accrual used on 2009 report.			\$	6,600	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		\$	6,099	2	
3. Under or (over) accrual (line 2 minus line 1).			\$	(501)	3	
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	6,300	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.				262		
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.			\$	6,061	7	
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	2005	<u>5,938</u>			8	
	2006	<u>6,095</u>			9	
	2007	<u>6,090</u>			10	
	2008	<u>6,365</u>			11	
	2009	<u>6,099</u>			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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 10,476 B. General Construction Type: Exterior Brick & Concrete Frame Wood Number of Stories 1

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

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

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

N/A

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>75,359</u>	<u>2005</u>	<u>\$ 15,750</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	75,359		\$ 15,750	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	49		2005	1972	\$ 280,250	\$	25	\$ 11,209	\$ 11,209	\$ 61,651
5										
6										
7										
8										
	Improvement Type**									
9	Original Land		2005		10,000		15	667	667	3,668
10	Door Alarm		2007		1,636		15	109	109	382
11	Air Compressor		2007		1,302		15	87	87	304
12	New Roof		2007		29,725		20	1,486	1,486	5,201
13	Awning		2008		2,569		20	128	128	320
14										
15										
16										
17										
18										
19										
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30	Land Improvements Booked					667			(667)	
31	Building Booked					11,253			(11,253)	
32	Building Improvement Booked					1,478			(1,478)	
33										
34	2010-Home Office Allocation-Building Improvements				4,758			114	114	
35	2010-Home Office Allocation-Land Improvements				444			25	25	
36										

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70		\$ 330,684	\$ 13,398		\$ 13,825	\$ 427	\$ 71,526	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 79,470	\$ 10,582	\$ 10,451	\$ (131)	7-10 yrs.	\$ 55,022	71
72	Current Year Purchases	2,199	78	110	32	10 yrs.	110	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			2,473	2,473			74
75	TOTALS	\$ 81,669	\$ 10,660	\$ 13,034	\$ 2,374		\$ 55,132	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	N/A									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)	\$ 428,103	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 24,058	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 26,859	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,801	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 126,658	85

**

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88	N/A				88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	92
93			93
94			94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions. YES NO

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

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

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

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

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

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

YES NO

16. Rental Amount for movable equipment: \$ 8,218 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	2006 Ford E250	578.16	\$ 6,938	17
18					18
19					19
20					20
21	TOTAL		\$ 578.16	\$ 6,938	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2011 \$ _____

13. _____ /2012 \$ _____

14. _____ /2013 \$ _____

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

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

Enfield Rehabilitation & Health Care Center
0047464
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	\$	3,571
Dishwasher		708
Copier		3,686
Home Office Allocation		253
		<u>8,218</u>

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

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

Facility Name & ID Number Enfield Rehabilitation & Health Care Center

0047464

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	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 550	\$ 550	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>N/A</u>)	(11,002)	(11,002)	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	12,791	12,791	6
7	Other Prepaid Expenses	5,203	5,203	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Prepaid Mgmt. Fees</u>	25,000	25,000	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 32,542	\$ 32,542	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	25,750	15,750	13
14	Buildings, at Historical Cost	280,250	285,008	14
15	Leasehold Improvements, at Historical Cost	35,232	45,676	15
16	Equipment, at Historical Cost	78,330	81,669	16
17	Accumulated Depreciation (book methods)	(121,886)	(126,658)	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)	\$ 297,676	\$ 301,445	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 330,218	\$ 333,987	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 984,404	\$ 984,404	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	14,054	14,054	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,197	9,197	31
32	Accrued Real Estate Taxes(Sch.IX-B)	6,300	6,300	32
33	Accrued Interest Payable	859	859	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Payroll Withholdings</u>	12,538	12,538	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,027,352	\$ 1,027,352	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	191,509	191,509	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)	\$ 191,509	\$ 191,509	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,218,861	\$ 1,218,861	46
47	TOTAL EQUITY(page 18, line 24)	\$ (888,643)	\$ (884,874)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 330,218	\$ 333,987	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (619,914)	1
2	Restatements (describe):		2
3	Rounding	(1)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (619,915)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(268,728)	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)	\$ (268,728)	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)	\$ (888,643)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **Enfield Rehabilitation & Health Care Center**# **0047464**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.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 952,423	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 952,423	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	3,664	14
15	Telephone, Television and Radio	775	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 4,439	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Revenue</u>	91	28
28a	<u>Transportation Revenue</u>	555	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 646	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 957,508	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	354,394	31
32	Health Care	533,744	32
33	General Administration	249,269	33
B. Capital Expense			
34	Ownership	54,716	34
C. Ancillary Expense			
35	Special Cost Centers	7,285	35
36	Provider Participation Fee	26,828	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,226,236	40
41	Income before Income Taxes (line 30 minus line 40)**	(268,728)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (268,728)	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 Enfield Rehabilitation & Health Care Center

0047464

Report Period Beginning: 1/1/2010

Ending:

12/31/2010

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,080	2,080	\$ 48,040	\$ 23.10	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,016	3,108	63,876	20.55	3
4	Licensed Practical Nurses	6,534	6,682	110,892	16.60	4
5	CNAs & Orderlies	23,758	24,506	241,684	9.86	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	473	538	5,922	11.01	9
10	Activity Assistants	1,177	1,177	9,972	8.47	10
11	Social Service Workers	1,591	1,711	17,186	10.04	11
12	Dietician					12
13	Food Service Supervisor	1,899	2,067	24,636	11.92	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,417	8,722	77,219	8.85	15
16	Dishwashers					16
17	Maintenance Workers	1,890	1,958	19,641	10.03	17
18	Housekeepers	8,384	8,837	76,061	8.61	18
19	Laundry					19
20	Administrator	2,349	2,349	59,286	25.24	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Transportation</u>	475	475	3,882	8.17	33
34	TOTAL (lines 1 - 33)	62,043	64,210	\$ 758,297 *	\$ 11.81	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 975	1(3)	35
36	Medical Director	Monthly	4,200	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,530	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)		\$ 6,705		49

C. CONTRACT NURSES

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

Enfield Rehabilitation & Health Care Center

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

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator				#DIV/0!
Restorative Aide				#DIV/0!
Certified Medical Technician				#DIV/0!
Alzheimer's Coordinator				#DIV/0!
Restorative Nurse				#DIV/0!
Transportation				#DIV/0!
Marketing				#DIV/0!
TOTAL				

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Henry McGill	Administrator	0	\$ 37,724	Workers' Compensation Insurance	\$ 19,253	IDPH License Fee	\$ 700	
Patti Scates	Administrator	0	21,562	Unemployment Compensation Insurance	15,895	Advertising: Employee Recruitment		
				FICA Taxes	52,785	Health Care Worker Background Check		
				Employee Health Insurance	3,102	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks	47 474	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	678	
				Employee Relations	804			
				Employee Retirement	167			
				Home Office Allocation	1,597	Home Office Allocation	926	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 59,286					
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
Description			Amount				Less: Public Relations Expense ()	
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 115,000				Non-allowable advertising ()	
							Yellow page advertising ()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 115,000				TOTAL (agree to Sch. V, line 20, col. 8)	
(Attach a copy of any management service agreement)							\$ 2,778	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
E-Data Health	Computer Services		\$ 2,700				Out-of-State Travel	\$
Frontier	Computer Services		360					
Verizon Online	Computer Services		421				In-State Travel	
Senior Consultant	Feasibility Study		4,000	N/A				
Midwest Env. Consulting	Environmental Study		1,681				Seminar Expense	
							Home Office Allocation	15
							Entertainment Expense ()	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 9,162				TOTAL \$ 15	

* Attach copy of IMRF notifications

**See instructions.

Enfield Rehabilitation & Health Care Center

0047464

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)		9,162

Home Office Allocation

Heyl, Royster, Voelker & Allen	Legal	2
Healthcare Resources International	Legal	25
Ginoli & Company	Accountants	797
Bank of America	Accountants	79
Miscellaneous Vendors	Computer Services	12
VisionShare	Computer Services	109
Advanced Answers on Demand	Computer Services	683
Access 2 Go	Computer Services	111
Kemper Technology	Computer Services	94
MediFax	Computer Services	39
LogmeIn	Computer Services	28
Simple LTC	Computer Services	435
Optimizer Systems	Other Professional I	16
Clifton Gunderson	Other Professional I	49
Total (agree to Schedule V, line 19, column 8)		<u>11,641</u>

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

Schedule 21B

XIX. SUPPORT SCHEDULE

Legal Fees

Facility

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

Facility Name & ID Number Enfield Rehabilitation & Health Care Center# 0047464Report Period Beginning: 1/1/2010Ending: 12/31/2010**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. _____
- (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. \$ 6,401 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. \$ 26,828
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. \$ 3,664
- (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. \$ 553
c. What percent of all travel expense relates to transportation of nurses and patients? 100
d. Have vehicle usage logs been maintained? Adequate records have been maintained.
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli & Company
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.