		FOR BHF USE				

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

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

I. **IDPH License ID Number:** 0046086

Facility Name: Havana Health Care Center

Address: 609 North Harpham Street (Number) Havana (City) 62644 (Zip Code)

County: Mason

Telephone Number: (309) 543-6121 Fax # (309) 543-1233

HFS ID Number:

Date of Initial License for Current Owners: 03/01/01

Type of Ownership:

[ ] VOLUNTARY,NON-PROFIT
- [ ] Charitable Corp.
- [ ] Trust

IRS Exemption Code

[X] PROPRIETARY
- [ ] Individual
- [ ] Partnership
- [ ] Corporation
- [X] "Sub-S" Corp.
- [ ] Limited Liability Co.
- [ ] Trust
- [ ] Other

[ ] GOVERNMENTAL
- [ ] State
- [ ] County
- [ ] 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 Havana Health Care Center # 0046086 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	20	Skilled (SNF)	20	7,300	1
2		Skilled Pediatric (SNF/PED)			2
3	78	Intermediate (ICF)	78	28,470	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	98	TOTALS	98	35,770	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			2,315	2,315	8
9	SNF/PED					9
10	ICF	16,650	6,816		23,466	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,650	6,816	2,315	25,781	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.07%

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)
Jail Meals

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 3/1/2001

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 3/1/2001 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 20 and days of care provided 2,127

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

Is your fiscal year identical to your tax year? YES [X] NO [ ]

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

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

Facility Name & ID Number Havana Health Care Center # 0046086 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	180,690	31,203		211,893		211,893	4,802	216,695			1
2	Food Purchase		196,674		196,674		196,674	(159,641)	37,033			2
3	Housekeeping	101,196	16,961		118,157		118,157	57	118,214			3
4	Laundry	43,177	17,435		60,612		60,612		60,612			4
5	Heat and Other Utilities			95,413	95,413		95,413	477	95,890			5
6	Maintenance	50,664	17,343	44,221	112,228		112,228	2,795	115,023			6
7	Other (specify):* Home Off. Ben. All.							1,125	1,125			7
8	TOTAL General Services	375,727	279,616	139,634	794,977		794,977	(150,385)	644,592			8
	B. Health Care and Programs											
9	Medical Director			12,750	12,750		12,750		12,750			9
10	Nursing and Medical Records	1,074,961	65,330	5,181	1,145,472		1,145,472	(417)	1,145,055			10
10a	Therapy	91,676	624	37,125	129,425		129,425		129,425			10a
11	Activities	50,882	805	283	51,970		51,970	(278)	51,692			11
12	Social Services	25,903	100		26,003		26,003		26,003			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Off. Ben. All.											15
16	TOTAL Health Care and Programs	1,243,422	66,859	55,339	1,365,620		1,365,620	(695)	1,364,925			16
	C. General Administration											
17	Administrative							54,487	54,487			17
18	Directors Fees											18
19	Professional Services			7,292	7,292		7,292	5,321	12,613			19
20	Dues, Fees, Subscriptions & Promotions			2,590	2,590		2,590	1,193	3,783			20
21	Clerical & General Office Expenses	39,521	6,847	10,568	56,936		56,936	47,564	104,500			21
22	Employee Benefits & Payroll Taxes			288,283	288,283		288,283		288,283			22
23	Inservice Training & Education							343	343			23
24	Travel and Seminar							40	40			24
25	Other Admin. Staff Transportation			12,573	12,573		12,573	4,301	16,874			25
26	Insurance-Prop.Liab.Malpractice			37,628	37,628		37,628	713	38,341			26
27	Other (specify):* Home Off. Ben. All.							19,504	19,504			27
28	TOTAL General Administration	39,521	6,847	358,934	405,302		405,302	133,466	538,768			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,658,670	353,322	553,907	2,565,899		2,565,899	(17,614)	2,548,285			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 Havana Health Care Center #0046086 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			58,921	58,921		58,921	33,541	92,462			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			161,826	161,826		161,826	984	162,810			32
33	Real Estate Taxes			84,512	84,512		84,512	(1,828)	82,684			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			5,346	5,346		5,346	659	6,005			35
36	Other (specify):*											36
37	TOTAL Ownership			310,605	310,605		310,605	33,356	343,961			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		73,229		73,229		73,229		73,229			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			53,655	53,655		53,655		53,655			42
43	Other (specify):* Non-allowable Cost	37,793	1,340	67,678	106,811		106,811	(106,811)				43
44	TOTAL Special Cost Centers	37,793	74,569	121,333	233,695		233,695	(106,811)	126,884			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,696,463	427,891	985,845	3,110,199		3,110,199	(91,069)	3,019,130			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 Havana Health Care Center # 0046086 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	(1,054)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,148)	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	28,009	30		9
10	Interest and Other Investment Income	(5,391)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(66)	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	(200)	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	(19,786)	43		24
25	Fund Raising, Advertising and Promotional	(43,128)	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	(203,705)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (247,469)		$	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)	156,400	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 156,400		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (91,069)		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

Havana Health Care Center

ID# 0046086

Report Period Beginning: 1/1/2010

Ending: 12/31/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs-Part A	$ (30,539)	43	1
2	X-Rays-Part A	(9,712)	43	2
3	Resident Flower	(1,436)	43	3
4	Disallowed Special Events	204	43	4
5	Offset of Nursing Supplies Income	(490)	10	5
6	Offset of Office Supplies Income	(232)	21	6
7	Disallowed Chamber of Commerce Dues	(125)	20	7
8	Offset of Jail Meals Revenue	(158,587)	2	8
9	Offset of Transportation Revenue	(278)	11	9
10	Disallowed Real Estate Tax Late Fees	(2,510)	33	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
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	(203,705)		49

Facility Name & ID Number Havana Health Care Center # 0046086 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

VII. RELATED PARTIES

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

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

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

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

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	$	Petersen Health Care, Inc.	100.00%	$ 4,802	$ 4,802	1
2	V	2	Food		Petersen Health Care, Inc.	100.00%	0		2
3	V	3	Housekeeping		Petersen Health Care, Inc.	100.00%	57	57	3
4	V	4	Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5	Utilities		Petersen Health Care, Inc.	100.00%	477	477	5
6	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	2,795	2,795	6
7	V	7	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,125	1,125	7
8	V	10	Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	73	73	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		Petersen Health Care, Inc.	100.00%	54,487	54,487	11
12	V	19	Professional Services		Petersen Health Care, Inc.	100.00%	5,321	5,321	12
13	V								13
14	Total			$			$ 69,137	$ * 69,137	14

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

Facility Name & ID Number Havana Health Care Center # 0046086 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%	$ 1,318	$ 1,318	15
16	V	21	Clerical and General Office		Petersen Health Care, Inc.	100.00%	47,796	47,796	16
17	V	23	Inservice Training and Education		Petersen Health Care, Inc.	100.00%	343	343	17
18	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	40	40	18
19	V	25	Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	4,301	4,301	19
20	V	26	Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	713	713	20
21	V	27	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	19,504	19,504	21
22	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	5,532	5,532	22
23	V	32	Interest		Petersen Health Care, Inc.	100.00%	6,375	6,375	23
24	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	682	682	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%	659	659	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			$			$ 87,263	$ * 87,263	39

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

Facility Name & ID Number Havana Health Care Center # 0046086 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	
					Compensation Received From Other	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	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	Mark Petersen	President	Administrative	100.00	178,975	0.98	1.64	Salary	$ 3,275	L17, C7	1
2											2
3											3
4											4
5		See Attached Schedule 7A									5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 3,275		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 Havana Health Care Center # 0046086 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

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

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

	1 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	25,781	$ 4,802	1
2	2	Food	Resident Days	1,527,029	77	0	0	25,781	0	2
3	3	Housekeeping	Resident Days	1,527,029	77	3,369	0	25,781	57	3
4	4	Laundry	Resident Days	1,527,029	77	0	0	25,781	0	4
5	5	Utilities	Resident Days	1,527,029	77	28,267	0	25,781	477	5
6	6	Maintenance	Resident Days	1,527,029	77	165,545	121,901	25,781	2,795	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,527,029	77	66,650	0	25,781	1,125	7
8	10	Nursing and Medical Records	Resident Days	1,527,029	77	4,339	0	25,781	73	8
9	10A	Therapy	Resident Days	1,527,029	77	0	0	25,781	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,527,029	77	0	0	25,781	0	10
11	17	Administrative	Resident Days	1,527,029	77	5,157,152	5,157,152	25,781	54,487	11
12	19	Professional Services	Resident Days	1,527,029	77	315,156	0	25,781	5,321	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,527,029	77	78,050	0	25,781	1,318	13
14	21	Clerical and General Office	Resident Days	1,527,029	77	2,830,968	2,420,380	25,781	47,796	14
15	23	Inservice Training & Education	Resident Days	1,527,029	77	20,336	0	25,781	343	15
16	24	Travel and Seminar	Resident Days	1,527,029	77	2,344	0	25,781	40	16
17	25	Other Admin. Staff Transport.	Resident Days	1,527,029	77	254,752	0	25,781	4,301	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,527,029	77	42,233	0	25,781	713	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,527,029	77	1,155,252	0	25,781	19,504	19
20	30	Depreciation	Resident Days	1,527,029	77	327,648	0	25,781	5,532	20
21	32	Interest	Resident Days	1,527,029	77	377,597	0	25,781	6,375	21
22	33	Real Estate Taxes	Resident Days	1,527,029	77	40,405	0	25,781	682	22
23	34	Rent-Facility and Grounds	Resident Days	1,527,029	77	0	0	25,781	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,527,029	77	39,061	0	25,781	659	24
25	TOTALS					$ 11,193,551	$ 7,982,443		$ 156,400	25

Facility Name & ID Number Havana Health Care Center # 0046086 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**		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	1/17/07	$ 3,075,000	$ 2,905,177	12/31/13	Varies	$ 160,933	1
2	Community State Bank		X	Ford E250 Van	$559.17	9/16/09	18,372	11,144	9/15/12	0.0595	893	2
3							Interest Income Offset				(5,391)	3
4							Home Office Allocation-PHC				6,375	4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$559.17		$ 3,093,372	$ 2,916,321			$ 162,810	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 3,093,372	$ 2,916,321			$ 162,810	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 **Havana Health Care Center** # 0046086 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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.

Item		Amount	Line
1. Real Estate Tax accrual used on 2009 report.		$ 86,500	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	$ 83,002	2
3. Under or (over) accrual (line 2 minus line 1).		$ (3,498)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 85,500	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. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	Home Office Allocation	682 $	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 82,684	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	69,249	8
	2006	77,119	9
	2007	81,610	10
	2008	84,008	11
	2009	83,002	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 Havana Health Care Center COUNTY Mason

FACILITY IDPH LICENSE NUMBER 0046086

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.	005-1479000	Long-Term Care Facility	$ 82,976.02	$ 82,976.02
2.	005-3910000	Land	$ 26.15	$ 26.15
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 83,002.17	$ 83,002.17

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,208 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	418,945	2001	$ 200,000	1
2					2
3	TOTALS	418,945		$ 200,000	3

Facility Name & ID Number Havana Health Care Center # 0046086 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	98		2001	1971	$ 1,314,000	$	35	$ 37,543	$ 37,543	$ 356,658	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Roof			2001	22,650		20	1,133	1,133	10,763	9
10	Flooring			2001	5,890		20	295	295	2,802	10
11	Landscaping			2001	8,984		20	449	449	4,266	11
12	A/C Heating Unit			2001	2,046		20	102	102	1,093	12
13	Fencing			2002	758		20	38	38	323	13
14	Roofing			2002	500		20	25	25	213	14
15	Ceiling Tiles			2003	9,516		20	476	476	3,570	15
16	Doors			2004	2,305		20	115	115	748	16
17	Nursing Station			2004	8,100		20	405	405	2,633	17
18	Furnace			2004	3,382		20	169	169	1,099	18
19	Water Heater			2004	2,281		20	114	114	741	19
20	Concrete slab work			2005	3,919		20	196	196	1,078	20
21	Roofing			2006	2,991		20	150	150	675	21
22	Walk-In Freezer			2007	14,817		20	741	741	2,593	22
23	Roof Repairs			2008	2,890		20	144	144	360	23
24	A/C Unit			2010	3,091		7	221	221	221	24
25	Fire Alarm Panel			2010	2,648		7	189	189	189	25
26	Roof Repairs			2010	10,896		7	778	778	778	26
27	Sprinkler System Replacement			2010	96,315		15	3,211	3,211	3,211	27
28											28
29											29
30	Land Improvements Booked					531			(531)		30
31	Building Booked					33,692			(33,692)		31
32	Building Improvement Booked					7,709			(7,709)		32
33											33
34	2010-Home Office Allocation-Building Improvements				12,392			297	297		34
35	2010-Home Office Allocation-Land Improvements				1,157			64	64		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 Havana Health Care Center # 0046086 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)		$ 1,531,528	$ 41,932		$ 46,855	$ 4,923	$ 394,014	70

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

Facility Name & ID Number Havana Health Care Center # 0046086 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	$ 416,971	$ 9,860	$ 33,086	$ 23,226	5-10 yrs.	$ 407,550	71
72	Current Year Purchases	3,102	295	155	(140)	10 yrs.	155	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			5,532	5,532			74
75	TOTALS	$ 420,073	$ 10,155	$ 38,773	$ 28,618		$ 407,705	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Use	1999 Oldsmobile	2001	$ 12,992	$	$	$		$ 12,992	76
77	Facility Use	2001 Chevrolet	2003	10,002					10,002	77
78	Facility Use	1997 Jeep	2004	7,333					7,333	78
79	Facility Use	2009 Ford E250 Van	2009	34,172	6,834	6,834		5	10,251	79
80	TOTALS			$ 64,499	$ 6,834	$ 6,834	$		$ 40,578	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)	$ 2,216,100	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 58,921	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 92,462	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 33,541	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 842,297	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: *

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: $ 6,005 Description: See Attached Schedule 14A
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Havana Health Care Center
0046086
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

Description		Amount
Medical Equipment	$	1,273
Dishwasher		1,008
Copier		3,065
Home Office Allocation		659
		6,005

Facility Name & ID Number Havana Health Care Center # 0046086 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.

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

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A(3)	1626	hrs	$ 32,814	1,014	$ 15,217	$	2,640	$ 48,031	1
2	Licensed Speech and Language Development Therapist	10A(3)		hrs		494	7,416		494	7,416	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10A (1,2,3)	390	hrs	16,298	953	14,298	624	1,343	31,220	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				73,229		73,229	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): Consultant	10A(3)				13	194		13	194	12
13	Other (specify):										13
14	TOTAL				$ 49,112	2,474	$ 37,125	$ 73,853	4,490	$ 160,090	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 Havana Health Care Center # 0046086 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	$ 3,408,321	$ 3,408,321	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 29,000)	156,656	156,656	3
4	Supply Inventory (priced at Cost)	15,521	15,521	4
5	Short-Term Investments			5
6	Prepaid Insurance	25,582	25,582	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	1,010,013	1,010,013	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,616,093	$ 4,616,093	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	208,984	200,000	13
14	Buildings, at Historical Cost	1,314,000	1,326,392	14
15	Leasehold Improvements, at Historical Cost	176,196	205,136	15
16	Equipment, at Historical Cost	500,381	484,572	16
17	Accumulated Depreciation (book methods)	(821,037)	(842,297)	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)**	$ 1,378,524	$ 1,373,803	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,994,617	$ 5,989,896	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 465,476	$ 465,476	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	97,091	97,091	30
31	Accrued Taxes Payable (excluding real estate taxes)	18,880	18,880	31
32	Accrued Real Estate Taxes(Sch.IX-B)	85,500	85,500	32
33	Accrued Interest Payable	14,153	14,153	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	41,123	41,123	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 722,223	$ 722,223	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	11,144	11,144	39
40	Mortgage Payable	2,905,177	2,905,177	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,916,321	$ 2,916,321	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,638,544	$ 3,638,544	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,356,073	$ 2,351,352	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,994,617	$ 5,989,896	48

*(See instructions.)

Facility Name & ID Number Havana Health Care Center # 0046086 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,040,027	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)**	$ 2,040,028	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	316,045	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)**	$ 316,045	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,356,073	24 *

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

Facility Name & ID Number Havana Health Care Center # 0046086 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	$ 3,133,814	1
2	Discounts and Allowances for all Levels	(281,094)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,852,720	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	236,795	6
7	Oxygen	1,720	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 238,515	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	1,054	14
15	Telephone, Television and Radio	2,072	15
16	Rental of Facility Space		16
17	Sale of Drugs	114,466	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	49,819	20
21	Other Medical Services	2,620	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 170,031	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5,391	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 5,391	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Miscellaneous & Transportation Revenue	1,000	28
28a	Jail Meals Revenue	158,587	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 159,587	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,426,244	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	794,977	31
32	Health Care	1,365,620	32
33	General Administration	405,302	33
	B. Capital Expense		
34	Ownership	310,605	34
	C. Ancillary Expense		
35	Special Cost Centers	180,040	35
36	Provider Participation Fee	53,655	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,110,199	40
41	**Income before Income Taxes (line 30 minus line 40)****	316,045	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 316,045	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 Havana Health Care Center # 0046086 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	$ 49,647	$ 23.87	1
2	Assistant Director of Nursing	4,072	4,322	45,023	10.42	2
3	Registered Nurses	5,372	5,612	155,371	27.69	3
4	Licensed Practical Nurses	12,492	13,287	244,333	18.39	4
5	CNAs & Orderlies	47,366	48,741	528,438	10.84	5
6	CNA Trainees					6
7	Licensed Therapist	1,862	2,016	49,112	24.36	7
8	Rehab/Therapy Aides	1,907	1,987	42,564	21.42	8
9	Activity Director	1,977	2,068	20,906	10.11	9
10	Activity Assistants	2,432	2,633	24,553	9.33	10
11	Social Service Workers	2,080	2,080	25,903	12.45	11
12	Dietician					12
13	Food Service Supervisor	4,160	4,160	51,238	12.32	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,980	14,490	129,452	8.93	15
16	Dishwashers					16
17	Maintenance Workers	3,782	3,942	50,664	12.85	17
18	Housekeepers	10,181	10,442	101,196	9.69	18
19	Laundry	4,304	4,535	43,177	9.52	19
20	Administrator	1,900	1,900	51,212	26.95	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,657	2,745	39,521	14.40	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) See Sch 20A	4,247	4,318	95,365	22.09	33
34	TOTAL (lines 1 - 33)	126,851	131,358	$ 1,747,675 *	$ 13.30	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	12,750	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,149	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)		$ 16,899		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

Havana 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	2,018	2,089	52,149	24.96
Transportation	557	557	5,423	9.74
Marketing	1,672	1,672	37,793	22.60
TOTAL	4,247	4,318	95,365	

Facility Name & ID Number Havana Health Care Center # 0046086 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %		Amount
Angel Bollinger	Administrator	0	$	41,731
Lauren Elgin	Administrator	0		9,481
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$	51,212

B. Administrative - Other

Description		Amount
N/A	$	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$	

C. Professional Services

Vendor/Payee	Type		Amount
Clifton Gunderson	Accounting Services	$	3,000
E-Health Data Solutions	Computer Services		3,420
CenturyLink	Computer Services		872
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$	7,292

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance	$	38,506
Unemployment Compensation Insurance		34,561
FICA Taxes		126,562
Employee Health Insurance		84,326
Employee Meals		
Illinois Municipal Retirement Fund (IMRF)*		
Employee Relations		1,924
Employee Retirement		2,010
Life Insurance		394
TOTAL (agree to Schedule V, line 22, col.8)	$	288,283

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

Description	Line #		Amount
		$	
N/A			
TOTAL		$	

F. Dues, Fees, Subscriptions and Promotions

Description			Amount
IDPH License Fee		$	
Advertising: Employee Recruitment			489
Health Care Worker Background Check			
(Indicate # of checks performed)			
Patient Background Checks	132		1,320
Miscellaneous Licenses & Permits			656
Miscellaneous Dues & Subscriptions			125
IHCA Dues			0
Home Office Allocation			1,318
Less: Public Relations Expense			(125)
Non-allowable advertising		(	)
Yellow page advertising		(	)
TOTAL (agree to Sch. V, line 20, col. 8)		$	3,783

G. Schedule of Travel and Seminar**

Description		Amount
Out-of-State Travel	$	
In-State Travel		
Seminar Expense		
Home Office Allocation		40
Entertainment Expense	(	)
TOTAL (agree to Sch. V, line 24, col. 8)	$	40

* Attach copy of IMRF notifications

**See instructions.

Havana Health Care Center
0046086
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)		7,292
Home Office Allocation		
Heyl, Royster, Voelker & Allen	Legal	5
Healthcare Resources International	Legal	66
Ginoli & Company	Accountants	941
Bank of America	Accountants	207
Miscellaneous Vendors	Computer Services	31
VisionShare	Computer Services	283
Advanced Answers on Demand	Computer Services	1,779
Access 2 Go	Computer Services	289
Kemper Technology	Computer Services	245
MediFax	Computer Services	101
LogmeIn	Computer Services	72
Simple LTC	Computer Services	1,134
Optimizer Systems	Other Professional Fees	41
Clifton Gunderson	Other Professional Fees	127
Total (agree to Schedule V, line 19, column 8)		12,613

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
					Amount of Expense Amortized Per Year								
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	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		$		$	$	$	$	$	$	$	$	$

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **12,266** 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. $ **53,655**
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. $ **1,054**

(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. $ **278**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? **N/A**
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Ginoli & Company**

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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.