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: 0026518

Facility Name: Kewanee Care Home

Address: 144 Junior Avenue (Number) Kewanee (City) 61443 (Zip Code)

County: Henry

Telephone Number: (309) 853-4429 **Fax #** (309) 853-4400

HFS ID Number:

Date of Initial License for Current Owners: 06/01/76

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

Officer or Administrator of Provider

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

Paid Preparer

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

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

Facility Name & ID Number Kewanee Care Home # 0026518 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	27	Skilled (SNF)	27	9,855	1
2		Skilled Pediatric (SNF/PED)			2
3	57	Intermediate (ICF)	57	20,805	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	84	TOTALS	84	30,660	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			4,038	4,038	8
9	SNF/PED					9
10	ICF	12,403	6,080		18,483	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,403	6,080	4,038	22,521	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.45%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 6/1/1976

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 27 and days of care provided 3,525

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 Kewanee Care Home # 0026518 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	129,521	12,184		141,705		141,705	4,195	145,900			1
2	Food Purchase		125,133		125,133		125,133	(3,223)	121,910			2
3	Housekeeping	122,116	33,360		155,476		155,476	50	155,526			3
4	Laundry	28,508	15,045		43,553		43,553		43,553			4
5	Heat and Other Utilities			66,306	66,306		66,306	417	66,723			5
6	Maintenance	42,224	16,527	53,794	112,545		112,545	2,441	114,986			6
7	Other (specify):* Home Off. Ben. All.							983	983			7
8	TOTAL General Services	322,369	202,249	120,100	644,718		644,718	4,863	649,581			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	974,834	63,271	9,887	1,047,992		1,047,992	(236)	1,047,756			10
10a	Therapy	46,254	1,112	242,083	289,449		289,449		289,449			10a
11	Activities	52,298	253	(94)	52,457		52,457	(499)	51,958			11
12	Social Services	46,543			46,543		46,543		46,543			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Off. Ben. All.											15
16	TOTAL Health Care and Programs	1,119,929	64,636	263,876	1,448,441		1,448,441	(735)	1,447,706			16
	C. General Administration											
17	Administrative							70,275	70,275			17
18	Directors Fees											18
19	Professional Services			10,172	10,172		10,172	4,648	14,820			19
20	Dues, Fees, Subscriptions & Promotions			6,663	6,663		6,663	876	7,539			20
21	Clerical & General Office Expenses	52,056	6,063	11,737	69,856		69,856	41,638	111,494			21
22	Employee Benefits & Payroll Taxes			229,067	229,067		229,067		229,067			22
23	Inservice Training & Education			75	75		75	300	375			23
24	Travel and Seminar							35	35			24
25	Other Admin. Staff Transportation			8,839	8,839		8,839	3,757	12,596			25
26	Insurance-Prop.Liab.Malpractice			33,041	33,041		33,041	623	33,664			26
27	Other (specify):* Home Off. Ben. All.							17,038	17,038			27
28	TOTAL General Administration	52,056	6,063	299,594	357,713		357,713	139,190	496,903			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,494,354	272,948	683,570	2,450,872		2,450,872	143,318	2,594,190			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 Kewanee Care Home #0026518 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			63,220	63,220		63,220	30,723	93,943			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			305,978	305,978		305,978	(1,448)	304,530			32
33	Real Estate Taxes			66,046	66,046		66,046	(1,256)	64,790			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			14,813	14,813		14,813	576	15,389			35
36	Other (specify):*											36
37	**TOTAL Ownership**			450,057	450,057		450,057	28,595	478,652			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		126,581		126,581		126,581		126,581			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			45,990	45,990		45,990		45,990			42
43	Other (specify):* Non-allowable Cost		649	54,638	55,287		55,287	(55,287)				43
44	**TOTAL Special Cost Centers**		127,230	100,628	227,858		227,858	(55,287)	172,571			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,494,354	400,178	1,234,255	3,128,787		3,128,787	116,626	3,245,413			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 Kewanee Care Home # 0026518 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,223)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	25,891	30		9
10	Interest and Other Investment Income	(3,280)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(202)	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	(8,775)	43		18
19	Entertainment				19
20	Contributions	(587)	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	(17,992)	43		24
25	Fund Raising, Advertising and Promotional	(5,609)	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	(28,899)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (42,676)		$	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)	159,302	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 159,302		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 116,626		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

Kewanee Care Home

ID# 0026518

Report Period Beginning: 1/1/2010

Ending: 12/31/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs-Part A	$ (17,867)	43	1
2	X-Rays-Part A	(4,459)	43	2
3	Offset of Nursing Supplies Income	(300)	10	3
4	Disallowed mortgage int. on non-care house	(3,737)	32	4
5	Offset of Transportation Income	(499)	11	5
6	Offset Chamber of Commerce Dues	(275)	20	6
7	Offset of Office Supplies Income	(114)	21	7
8	Disallowed Special Events	204	43	8
9	Disallowed Real Estate Tax Late Fees	(1,852)	33	9
10				10
11				11
12				12
13				13
14				14
15				15
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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**	(28,899)		49

Facility Name & ID Number Kewanee Care Home # 0026518 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%	$ 4,195	$ 4,195	1
2	V	2	Food		Petersen Health Care, Inc.	100.00%	0		2
3	V	3	Housekeeping		Petersen Health Care, Inc.	100.00%	50	50	3
4	V	4	Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5	Utilities		Petersen Health Care, Inc.	100.00%	417	417	5
6	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	2,441	2,441	6
7	V	7	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	983	983	7
8	V	10	Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	64	64	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%	70,275	70,275	11
12	V	19	Professional Services		Petersen Health Care, Inc.	100.00%	4,648	4,648	12
13	V								13
14	Total			$			$ 83,073	$ * 83,073	14

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

Facility Name & ID Number Kewanee Care Home # 0026518 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%	$ 1,151	$ 1,151	15
16	V	21	Clerical and General Office		Petersen Health Care, Inc.	100.00%	41,752	41,752	16
17	V	23	Inservice Training and Education		Petersen Health Care, Inc.	100.00%	300	300	17
18	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	35	35	18
19	V	25	Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	3,757	3,757	19
20	V	26	Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	623	623	20
21	V	27	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	17,038	17,038	21
22	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	4,832	4,832	22
23	V	32	Interest		Petersen Health Care, Inc.	100.00%	5,569	5,569	23
24	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	596	596	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%	576	576	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			$			$ 76,229	$ * 76,229	39

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

Facility Name & ID Number Kewanee Care Home # 0026518 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Petersen	President	Administrative	100.00	179,389	0.86	1.43	Salary	$ 2,861	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	$ 2,861		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 Kewanee Care Home # 0026518 Report Period Beginning: 1/1/2010 Ending: 2/31/2010

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	1,527,029	77	$ 284,427	$ 283,010	22,521	$ 4,195	1
2	2	Food	Resident Days	1,527,029	77	0	0	22,521	0	2
3	3	Housekeeping	Resident Days	1,527,029	77	3,369	0	22,521	50	3
4	4	Laundry	Resident Days	1,527,029	77	0	0	22,521	0	4
5	5	Utilities	Resident Days	1,527,029	77	28,267	0	22,521	417	5
6	6	Maintenance	Resident Days	1,527,029	77	165,545	121,901	22,521	2,441	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,527,029	77	66,650	0	22,521	983	7
8	10	Nursing and Medical Records	Resident Days	1,527,029	77	4,339	0	22,521	64	8
9	10A	Therapy	Resident Days	1,527,029	77	0	0	22,521	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,527,029	77	0	0	22,521	0	10
11	17	Administrative	Resident Days	1,527,029	77	5,157,152	5,157,152	22,521	70,275	11
12	19	Professional Services	Resident Days	1,527,029	77	315,156	0	22,521	4,648	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,527,029	77	78,050	0	22,521	1,151	13
14	21	Clerical and General Office	Resident Days	1,527,029	77	2,830,968	2,420,380	22,521	41,752	14
15	23	Inservice Training & Education	Resident Days	1,527,029	77	20,336	0	22,521	300	15
16	24	Travel and Seminar	Resident Days	1,527,029	77	2,344	0	22,521	35	16
17	25	Other Admin. Staff Transport.	Resident Days	1,527,029	77	254,752	0	22,521	3,757	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,527,029	77	42,233	0	22,521	623	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,527,029	77	1,155,252	0	22,521	17,038	19
20	30	Depreciation	Resident Days	1,527,029	77	327,648	0	22,521	4,832	20
21	32	Interest	Resident Days	1,527,029	77	377,597	0	22,521	5,569	21
22	33	Real Estate Taxes	Resident Days	1,527,029	77	40,405	0	22,521	596	22
23	34	Rent-Facility and Grounds	Resident Days	1,527,029	77	0	0	22,521	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,527,029	77	39,061	0	22,521	576	24
25	TOTALS					$ 11,193,551	$ 7,982,443		$ 159,302	25

Facility Name & ID Number Kewanee Care Home # 0026518 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Bank of America		X	Mortgage	Varies	1/17/07	$ 5,775,000	$ 5,456,065	12/31/13	Varies	$ 302,241	1
2												2
3							Interest Income Offset				(3,280)	3
4							Home Office Allocation-PHC				5,569	4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 5,775,000	$ 5,456,065			$ 304,530	9
	B. Non-Facility Related*											
10	Associated Bank		X	Mortgage on House	$879.00	11/16/05	70,500	42,189	10/16/15	0.0850	3,737	10
11												11
12									Disallowed interest		(3,737)	12
13												13
14	TOTAL Non-Facility Related				$879.00		$ 70,500	$ 42,189			$	14
15	TOTALS (line 9+line14)						$ 5,845,500	$ 5,498,254			$ 304,530	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 Kewanee Care Home # 0026518 **Report Period Beginning:** 1/1/2010 **Ending:** 12/31/2010

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 36,803	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2009	$ 48,577	2
3. Under or (over) accrual (line 2 minus line 1).		$ 11,774	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 52,420	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.	Home Office Allocation	596	
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.		$ 64,790	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005	22,716	8
2006	27,044	9
2007	29,813	10
2008	35,356	11
2009	48,577	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 Kewanee Care Home COUNTY Henry

FACILITY IDPH LICENSE NUMBER 0026518

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.	25-05-281-017	901 W. Mill St.	108.52	$ 108.52
2.	25-04-151-009	144 Junior Ave.	48,386.30	$ 48,386.30
3.	25-04-152-001	821 Dewey Ave.	$ 82.20	$ 82.20
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 48,577.02	$ 48,577.02

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number Kewanee Care Home # 0026518 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 12,548 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

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

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

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

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

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

N/A

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

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	42,000	1976	$ 25,000	1
2	Facility	11,250	1992	25,621	2
3	TOTALS	53,250		$ 50,621	3

Facility Name & ID Number Kewanee Care Home # 0026518 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	65		1976		$ 381,128	$	30	$	$	$ 381,128	4
5	11		1998	1998	753,696		40	18,842	18,842	237,579	5
6	8		2002	2002	672,751		40	16,819	16,819	109,322	6
7											7
8											8
	Improvement Type**										
9	Various			1984	14,365		30	479	479	12,487	9
10	Various			1985	7,400		10			7,400	10
11	Various			1987	10,278		10-15			10,278	11
12	Various			1988	14,958		10-15			14,958	12
13	Various			1989	1,900		15			1,900	13
14	Various			1991	8,793		15			8,793	14
15	Various			1992	16,898		12			16,898	15
16	Various			1993	4,962		10			4,962	16
17	Various			1994	22,158		15			22,158	17
18	Various			1995	31,243		20	1,562	1,562	24,248	18
19	Tile Flooring			1996	1,083		20	54	54	801	19
20	Curtains Custom			1996	1,275		20	64	64	875	20
21	Emergency Light			1996	304		20	15	15	220	21
22	Fire Alarm			1996	2,099		20	105	105	1,540	22
23	Tile Flooring			1996	1,287		20	64	64	933	23
24	Boiler			1996	2,996		20	150	150	2,138	24
25	Water Heater Repair			1996	1,010		20	51	51	761	25
26	Ceiling Repairs			1996	2,117		20	106	106	1,581	26
27	Piping Repairs			1996	855		20	43	43	641	27
28	Fire Alarm			1996	1,331		20	67	67	949	28
29	Fire System			1996	1,564		20	78	78	1,125	29
30	Landscaping			1996	9,815		20	491	491	7,160	30
31	Landscaping			1996	1,986		20	99	99	1,419	31
32	Chrome Door Knob			1996	72		20	4	4	59	32
33	Emergency Light			1996	182		20	9	9	135	33
34	Painting			1996	672		20	34	34	504	34
35	Floor Tile			1997	8,472		20	424	424	5,865	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 Kewanee Care Home # 0026518 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	Storage Shed	1997	$ 10,177	$	20	$ 509	$ 509	$ 6,829	37
38	Windows	1997	5,136		20	257	257	3,470	38
39	Ceiling Repairs	1997	8,291		20	415	415	5,533	39
40	Landscaping	1997	8,085		20	404	404	5,353	40
41	Landscaping	1997	1,298		20	65	65	861	41
42	Whirlpool	1997	9,343		20	467	467	6,110	42
43	Boiler	1997	3,000		20	150	150	1,975	43
44	Wing Additions	1997	3,700		20	185	185	2,420	44
45	Attic Piping	1997	3,318		20	166	166	2,227	45
46	Compressor	1997	809		20	40	40	523	46
47	Fire Alarm	1997	2,338		20	117	117	1,600	47
48	Code Alert Receiver	1997	1,863		20	93	93	1,271	48
49	New sign	1998	7,304		20	365	365	7,300	49
50	Landscaping	1998	21,500		20	1,075	1,075	13,617	50
51	Duct Work-New Wing	1999	1,494		20	75	75	862	51
52	Tiling	1999	914		20	46	46	529	52
53	Water Heater	1999	2,835		20	142	142	1,633	53
54	Water Heater	1999	3,766		20	188	188	2,162	54
55	Cubicle Partitions	1999	701		20	35	35	402	55
56	Beauty Salon	2000	943		20	47	47	494	56
57	Tile Flooring	2000	10,294		20	515	515	5,407	57
58	Lot/House Razed	2000	21,237		20	1,062	1,062	11,151	58
59	Concrete	2001	900		15	60	60	600	59
60	Landscaping	2001	1,045		15	70	70	701	60
61	Lighting	2001	3,438		39	88	88	880	61
62	Blinds/Curtains	2001	9,500		7			9,500	62
63	Landscaping	2002	24,614		15	1,641	1,641	13,948	63
64	Landscaping	2002	4,075		15	272	272	2,312	64
65	Architectural	2002	21,778		20	1,089	1,089	9,256	65
66	Carpeting	2002	2,551		20	128	128	1,088	66
67	Fire System	2002	4,677		20	234	234	1,989	67
68	Landscaping	2003	4,899		15	327	327	2,452	68
69	Simplex Time Clock	2004	3,198		10	320	320	2,080	69
70	TOTAL (lines 4 thru 69)		$ 2,186,671	$		$ 50,207	$ 50,207	$ 1,005,352	70

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

Facility Name & ID Number Kewanee Care Home # 0026518 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	
1	Totals from Page 12A, Carried Forward		$ 2,186,671	$		$ 50,207	$ 50,207	$ 1,005,352	1
2	Air Conditioner	2004	2,700		10	270	270	1,755	2
3	Side walks	2005	2,065		15	138	138	828	3
4	Floor covering	2005	13,891		7	1,984	1,984	11,904	4
5	Flooring	2006	28,527		25	1,141	1,141	5,135	5
6	Driveway	2007	7,101		15	473	473	1,656	6
7	Boiler	2007	2,895		10	290	290	1,015	7
8	Sprinkler System Repair	2008	2,583		5	516	516	1,290	8
9	Painting of Dining Room	2008	2,825		39	72	72	180	9
10	Sprinkler System Repair	2008	2,689		5	538	538	1,345	10
11	Fencing	2009	3,400		15	226	226	339	11
12	Boiler	2010	2,900		20	73	73	73	12
13	Compressor Repair	2010	2,639		7	94	94	94	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	Land Improvements Booked			4,376			(4,376)		27
28	Building Booked			19,325			(19,325)		28
29	Building Improvement Booked			28,284			(28,284)		29
30									30
31	2010-Home Office Allocation-Building Improvements		10,825			260	260		31
32	2010-Home Office Allocation-Land Improvements		1,010			56	56		32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,272,721	$ 51,985		$ 56,338	$ 4,353	$ 1,030,966	34

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

Facility Name & ID Number Kewanee Care Home # 0026518 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	$ 326,619	$ 7,606	$ 32,662	$ 25,056	7-10 yrs.	$ 299,724	71
72	Current Year Purchases	2,225	79	111	32	10 yrs.	111	72
73	Fully Depreciated Assets	107,989					107,989	73
74	Home Office Allocation			4,832	4,832			74
75	TOTALS	$ 436,833	$ 7,685	$ 37,605	$ 29,920		$ 407,824	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	1997 Dodge Caravan	1998	$ 32,369	$ 1,775	$	$ (1,775)		$ 32,369	76
77	Facility	2000 Town & Country	2002	35,088	1,775		(1,775)		35,088	77
78										78
79										79
80	TOTALS			$ 67,457	$ 3,550	$	$ (3,550)		$ 67,457	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)	$ 2,827,632	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 63,220	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 93,943	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 30,723	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,506,247	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Kewanee Care Home # 0026518 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

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

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 8,451 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

* 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.

Kewanee Care Home
0026518
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	$	4,730
Dishwasher		708
Copier		2,437
Home Office Allocation		576
		8,451

Facility Name & ID Number Kewanee Care Home # 0026518 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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

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

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

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Kewanee Care Home # 0026518 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A(1), 10A(3)	26 hrs	$ 1,020	4,807	$ 72,108	$	4,833	$ 73,128	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,873	28,095		1,873	28,095	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		9,459	141,880	1,112	9,459	142,992	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				126,581		126,581	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			$ 1,020	16,139	$ 242,083	$ 127,693	16,165	$ 370,796	14

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

STATE OF ILLINOIS

Facility Name & ID Number Kewanee Care Home # 0026518 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	$ 10,754,022	$ 10,754,022	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 7,500)	490,946	490,946	3
4	Supply Inventory (priced at Cost)	12,965	12,965	4
5	Short-Term Investments			5
6	Prepaid Insurance	22,649	22,649	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	960,271	960,271	8
9	Other(specify): Employee Advances	550	550	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 12,241,403	$ 12,241,403	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	162,096	50,621	13
14	Buildings, at Historical Cost	1,162,445	1,818,400	14
15	Leasehold Improvements, at Historical Cost	993,801	454,321	15
16	Equipment, at Historical Cost	538,565	504,290	16
17	Accumulated Depreciation (book methods)	(1,500,436)	(1,506,247)	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): Non-Care House	70,500	70,500	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,426,971	$ 1,391,885	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 13,668,374	$ 13,633,288	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 657,945	$ 657,945	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	89,885	89,885	30
31	Accrued Taxes Payable (excluding real estate taxes)	17,630	17,630	31
32	Accrued Real Estate Taxes(Sch.IX-B)	52,420	52,420	32
33	Accrued Interest Payable	26,581	26,581	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	34,688	34,688	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 879,149	$ 879,149	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	5,498,254	5,498,254	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Deferred Income	6,302	6,302	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 5,504,556	$ 5,504,556	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,383,705	$ 6,383,705	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 7,284,669	$ 7,249,583	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 13,668,374	$ 13,633,288	48

*(See instructions.)

Facility Name & ID Number Kewanee Care Home **#** 0026518 **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**	$ 6,705,125	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 6,705,125	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	579,544	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)**	$ 579,544	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)**	$ 7,284,669	24 *

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

Facility Name & ID Number Kewanee Care Home # 0026518 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	$ 3,348,777	1
2	Discounts and Allowances for all Levels	(416,624)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,932,153	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	519,978	6
7	Oxygen	135	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 520,113	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	3,223	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	224,610	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	17,508	20
21	Other Medical Services	6,531	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 251,872	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,280	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,280	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	414	28
28a	Transportation Revenue	499	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 913	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,708,331	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	644,718	31
32	Health Care	1,448,441	32
33	General Administration	357,713	33
	B. Capital Expense		
34	Ownership	450,057	34
	C. Ancillary Expense		
35	Special Cost Centers	181,868	35
36	Provider Participation Fee	45,990	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,128,787	40
41	**Income before Income Taxes (line 30 minus line 40)****	579,544	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 579,544	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 Kewanee Care Home # 0026518 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,600	2,600	$ 57,500	$ 22.12	1
2	Assistant Director of Nursing	1,473	1,473	46,743	31.73	2
3	Registered Nurses	1,138	1,138	35,092	30.84	3
4	Licensed Practical Nurses	16,939	17,487	301,272	17.23	4
5	CNAs & Orderlies	47,825	49,161	485,818	9.88	5
6	CNA Trainees					6
7	Licensed Therapist	26	26	1,020	39.23	7
8	Rehab/Therapy Aides	1,531	1,588	45,234	28.48	8
9	Activity Director	2,005	2,037	22,870	11.23	9
10	Activity Assistants	1,090	1,196	10,050	8.40	10
11	Social Service Workers	4,012	4,152	46,543	11.21	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	23,729	11.41	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,547	12,870	105,792	8.22	15
16	Dishwashers					16
17	Maintenance Workers	3,748	3,804	42,224	11.10	17
18	Housekeepers	13,694	14,043	122,116	8.70	18
19	Laundry	3,093	3,363	28,508	8.48	19
20	Administrator	2,171	2,171	67,414	31.05	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,125	4,184	52,056	12.44	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	4,657	4,792	67,787	14.15	33
34	TOTAL (lines 1 - 33)	124,754	128,165	$ 1,561,768 *	$ 12.19	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	12,000	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,650	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)		$ 15,650		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	97	$ 3,047	10(3)	50
51	Licensed Practical Nurses	23	628	10(3)	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	120	$ 3,675		53

Kewanee Care Home

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	2,695	2,695	48,409	17.96
Transportation	1,962	2,097	19,378	9.24
TOTAL	4,657	4,792	67,787	

Facility Name & ID Number Kewanee Care Home # 0026518 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Eric Clark	Administrator	0	$ 43,423
Doug Currier	Administrator	0	23,991
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 67,414

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, LLP	Accounting Services	$ 3,000
Comcast Communications	Computer Services	1,539
E-Health Data Solutions	Computer Services	3,420
Telleen, Horborg, Smith & Co.	Legal Services	113
Henry Co. Circuit Clerk	Legal Services	40
Estate of Mildred Poland	Legal Services	2,060
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 10,172

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 66,482
Unemployment Compensation Insurance	32,941
FICA Taxes	112,898
Employee Health Insurance	13,701
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	2,095
Employee Retirement	1,026
Life Insurance	(76)
TOTAL (agree to Schedule V, line 22, col.8)	$ 229,067

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

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks 280	2,800
Miscellaneous Licenses & Permits	1,023
Miscellaneous Dues & Subscriptions	275
IHCA Dues	0
Home Office Allocation	1,151
Curaspan Health Group	2,565
Less: Public Relations Expense	(275)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 7,539

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Home Office Allocation	35
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 35

**See instructions.

Kewanee Care Home
0026518
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)		10,172
Home Office Allocation		
Heyl, Royster, Voelker & Allen	Legal	4
Healthcare Resources International	Legal	57
Ginoli & Company	Accountants	822
Bank of America	Accountants	181
Miscellaneous Vendors	Computer Services	26
VisionShare	Computer Services	247
Advanced Answers on Demand	Computer Services	1,554
Access 2 Go	Computer Services	253
Kemper Technology	Computer Services	214
MediFax	Computer Services	89
Logmeln	Computer Services	63
Simple LTC	Computer Services	991
Optimizer Systems	Other Professional Fees	36
Clifton Gunderson	Other Professional Fees	111
Total (agree to Schedule V, line 19, column 8)		14,820

Facility Name & ID Number Kewanee Care Home # 0026518 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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

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

Facility Name & ID Number Kewanee Care Home # 0026518 **Report Period Beginning:** 1/1/2010 **Ending:** 12/31/2010

XX. GENERAL INFORMATION:

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

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

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **11,617** 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. $ **45,990**
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. $ **3,223**

(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. $ **499**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? **N/A**
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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

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