

		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.

<p><b>I. IDPH License ID Number:</b> <u>0050609</u></p> <p><b>Facility Name:</b> <u>Lebanon Care Center</u></p> <p><b>Address:</b> <u>1201 North Alton</u> <u>Lebanon</u> <u>62254</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>St. Clair</u></p> <p><b>Telephone Number:</b> <u>(618) 537-4401</u> <b>Fax #</b> <u>(618) 537-4447</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>7/31/2007</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT  <input type="checkbox"/> Charitable Corp.  <input type="checkbox"/> Trust            IRS Exemption Code _____         </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY  <input type="checkbox"/> Individual  <input type="checkbox"/> Partnership  <input type="checkbox"/> Corporation  <input type="checkbox"/> "Sub-S" Corp.  <input checked="" type="checkbox"/> Limited Liability Co.  <input type="checkbox"/> Trust  <input type="checkbox"/> Other _____         </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL  <input type="checkbox"/> State  <input type="checkbox"/> County  <input type="checkbox"/> Other _____         </td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Larry Templin</u> <b>Telephone Number:</b> <u>(309) 689-5869</u>  <b>Email Address:</b> _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p align="center">         I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2010</u> to <u>12/31/2010</u> 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.       </p> <p align="center">         Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.       </p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%; padding: 5px; vertical-align: top;">Officer or Administrator of Provider</td> <td style="padding: 5px;">         (Signed) _____          (Type or Print Name) <u>Mark B. Petersen</u>          (Title) <u>Chief Executive Officer</u> </td> </tr> <tr> <td style="padding: 5px; vertical-align: top;">Paid Preparer</td> <td style="padding: 5px;">         (Signed) _____          (Print Name and Title) _____          (Firm Name &amp; Address) _____          (Telephone) <u>( ) ( )</u> Fax # <u>( ) ( )</u> </td> </tr> </table> <p align="center"> <b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>  <b>201 S. Grand Avenue East</b>  <b>Springfield, IL 62763-0001</b> Phone # (217) 782-1630     </p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Mark B. Petersen</u> (Title) <u>Chief Executive Officer</u>	Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>( ) ( )</u> Fax # <u>( ) ( )</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Mark B. Petersen</u> (Title) <u>Chief Executive Officer</u>							
Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>( ) ( )</u> Fax # <u>( ) ( )</u>							

Facility Name & ID Number Lebanon Care Center

# 0050609 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	90	Skilled (SNF)	90	32,850	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	90	TOTALS	90	32,850	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	14,318	3,614	1,737	19,669	8	
9	SNF/PED					9	
10	ICF					10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	14,318	3,614	1,737	19,669	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 59.88%

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

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

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

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

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

I. On what date did you start providing long term care at this location?  
Date started 7/31/2007

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 7/31/2007 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 90 and days of care provided 1,496

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

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

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

Facility Name & ID Number Lebanon Care Center # 0050609 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	117,106	9,249	1,150	127,505		127,505	3,664	131,169		1
2	Food Purchase		98,641		98,641		98,641	(1,634)	97,007		2
3	Housekeeping	80,828	18,892		99,720		99,720	43	99,763		3
4	Laundry	26,242	8,352		34,594		34,594		34,594		4
5	Heat and Other Utilities			87,990	87,990		87,990	364	88,354		5
6	Maintenance	32,425	8,033	23,518	63,976		63,976	2,132	66,108		6
7	Other (specify):* Home Off. Ben. All.							859	859		7
8	<b>TOTAL General Services</b>	256,601	143,167	112,658	512,426		512,426	5,428	517,854		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			4,800	4,800		4,800		4,800		9
10	Nursing and Medical Records	756,198	52,269	3,418	811,885		811,885	56	811,941		10
10a	Therapy			375,807	375,807		375,807		375,807		10a
11	Activities	18,090	559	204	18,853		18,853		18,853		11
12	Social Services	25,335			25,335		25,335		25,335		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.										15
16	<b>TOTAL Health Care and Programs</b>	799,623	52,828	384,229	1,236,680		1,236,680	56	1,236,736		16
	<b>C. General Administration</b>										
17	Administrative			123,000	123,000		123,000	(71,174)	51,826		17
18	Directors Fees										18
19	Professional Services			6,009	6,009		6,009	5,158	11,167		19
20	Dues, Fees, Subscriptions & Promotions			10,947	10,947		10,947	1,581	12,528		20
21	Clerical & General Office Expenses	28,673	5,465	7,871	42,009		42,009	36,853	78,862		21
22	Employee Benefits & Payroll Taxes			180,584	180,584		180,584	3,503	184,087		22
23	Inservice Training & Education			450	450		450	262	712		23
24	Travel and Seminar							30	30		24
25	Other Admin. Staff Transportation			2,678	2,678		2,678	3,281	5,959		25
26	Insurance-Prop.Liab.Malpractice			34,556	34,556		34,556	544	35,100		26
27	Other (specify):* Home Off. Ben. All.							14,880	14,880		27
28	<b>TOTAL General Administration</b>	28,673	5,465	366,095	400,233		400,233	(5,082)	395,151		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,084,897	201,460	862,982	2,149,339		2,149,339	402	2,149,741		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 Lebanon Care Center

#0050609

Report Period Beginning:

1/1/2010

Ending:

12/31/2010

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			102,498	102,498		102,498	(6,379)	96,119			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			130,753	130,753		130,753	22,330	153,083			32
33	Real Estate Taxes			62,059	62,059		62,059	(1,207)	60,852			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			13,453	13,453		13,453	503	13,956			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			308,763	308,763		308,763	15,247	324,010			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		45,133		45,133		45,133		45,133			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			49,275	49,275		49,275		49,275			42
43	Other (specify):* <b>Non-allowable Cost</b>			29,933	29,933		29,933	(29,933)				43
44	<b>TOTAL Special Cost Centers</b>		45,133	79,208	124,341		124,341	(29,933)	94,408			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,084,897	246,593	1,250,953	2,582,443		2,582,443	(14,284)	2,568,159			45

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

**VI. ADJUSTMENT DETAIL**

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

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,634)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,692)	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	(10,599)	30		9
10	Interest and Other Investment Income	(875)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(110)	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	(4,160)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(12,489)	43		24
25	Fund Raising, Advertising and Promotional	(585)	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	(9,899)	Various		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (45,043)		\$	30

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

		1	2	
		<b>Amount</b>	<b>Reference</b>	
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)	30,759	Various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 30,759		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (14,284)		37

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

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

		1	2	3	4
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

<b>BHF USE ONLY</b>							
48		49		50		51	52

Lebanon Care CenterID# 0050609Report Period Beginning: 1/1/2010Ending: 12/31/2010

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (3,023)	43	1
2	X-Rays-Part A	(3,849)	43	2
3	Disallow Chamber of Commerce dues	(225)	20	3
4	Disallow Real Estate Tax penalty	(1,727)	33	4
5	Offset Miscellaneous Office Supplies Revenue	(50)	21	5
6	Pet Expense	(890)	43	6
7	Special Events	(135)	43	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
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42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(9,899)		49

**VII. RELATED PARTIES**

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 3,664	\$ 3,664	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	0		2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	43	43	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	364	364	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	2,132	2,132	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	859	859	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	56	56	8
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		10
11	V	17 Administrative	123,000	Petersen Health Care, Inc.	100.00%	51,826	(71,174)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	4,059	4,059	12
13	V							13
14	Total		\$ 123,000			\$ 63,003	\$ * (59,997)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	20 Dues, Fees, Subs & Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 1,005	\$	1,005	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	36,464		36,464	16
17	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	262		262	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	30		30	18
19	V	25 Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	3,281		3,281	19
20	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	544		544	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	14,880		14,880	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	4,220		4,220	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	4,864		4,864	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	520		520	24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0			25
26	V	35 Rent-Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	503		503	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		\$			\$ 66,573	\$ *	66,573	39

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



Facility Name & ID Number Lebanon Care Center# 0050609Report Period Beginning: 1/1/2010Ending: 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.  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 Dietary	\$	Petersen Health Network, LLC	100.00%	\$ 0	\$	15
16	V	2 Food		Petersen Health Network, LLC	100.00%	0		16
17	V	3 Housekeeping		Petersen Health Network, LLC	100.00%	0		17
18	V	4 Laundry		Petersen Health Network, LLC	100.00%	0		18
19	V	5 Utilities		Petersen Health Network, LLC	100.00%	0		19
20	V	6 Maintenance		Petersen Health Network, LLC	100.00%	0		20
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Network, LLC	100.00%	0		21
22	V	10 Nursing and Medical Records		Petersen Health Network, LLC	100.00%	0		22
23	V	10A Therapy		Petersen Health Network, LLC	100.00%	0		23
24	V	15 Mgmt. Allocation of Benefits		Petersen Health Network, LLC	100.00%	0		24
25	V	17 Administrative		Petersen Health Network, LLC	100.00%	0		25
26	V	19 Professional Services		Petersen Health Network, LLC	100.00%	1,099		1,099 26
27	V	20 Dues, Fees, Subs & Promotions		Petersen Health Network, LLC	100.00%	801		801 27
28	V	21 Clerical and General Office		Petersen Health Network, LLC	100.00%	439		439 28
29	V	22 Employee Benefits & Payroll		Petersen Health Network, LLC	100.00%	3,503		3,503 29
30	V	24 Travel and Seminar		Petersen Health Network, LLC	100.00%	0		30
31	V	25 Other Admin. Staff Transport.		Petersen Health Network, LLC	100.00%	0		31
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Network, LLC	100.00%	0		32
33	V	27 Mgmt. Allocation of Benefits		Petersen Health Network, LLC	100.00%	0		33
34	V	30 Depreciation		Petersen Health Network, LLC	100.00%	0		34
35	V	32 Interest		Petersen Health Network, LLC	100.00%	18,341		18,341 35
36	V	33 Real Estate Taxes		Petersen Health Network, LLC	100.00%	0		36
37	V	34 Rent-Facility and Grounds		Petersen Health Network, LLC	100.00%	0		37
38	V	35 Rent-Equipment & Vehicles		Petersen Health Network, LLC	100.00%	0		38
39	Total		\$			\$ 24,183	\$ *	24,183 39

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

Facility Name &amp; ID Number

Lebanon Care Center

# 0050609

Report Period Beginning:

1/1/2010

Ending:

12/31/2010

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Petersen	President	Administrative	100.00	179,751	0.75	1.25	Salary	\$ 2,499	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	\$ 2,499		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 Lebanon Care Center

# 0050609

Report Period Beginning:

1/1/2010

Ending: 2/31/2010

VIII. ALLOCATION OF INDIRECT COSTS

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

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	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,527,029	77	\$ 284,427	\$ 283,010	19,669	\$ 3,664	1
2	2	Food	Resident Days	1,527,029	77	0	0	19,669	0	2
3	3	Housekeeping	Resident Days	1,527,029	77	3,369	0	19,669	43	3
4	4	Laundry	Resident Days	1,527,029	77	0	0	19,669	0	4
5	5	Utilities	Resident Days	1,527,029	77	28,267	0	19,669	364	5
6	6	Maintenance	Resident Days	1,527,029	77	165,545	121,901	19,669	2,132	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,527,029	77	66,650	0	19,669	859	7
8	10	Nursing and Medical Records	Resident Days	1,527,029	77	4,339	0	19,669	56	8
9	10A	Therapy	Resident Days	1,527,029	77	0	0	19,669	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,527,029	77	0	0	19,669	0	10
11	17	Administrative	Resident Days	1,527,029	77	5,157,152	5,157,152	19,669	51,826	11
12	19	Professional Services	Resident Days	1,527,029	77	315,156	0	19,669	4,059	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,527,029	77	78,050	0	19,669	1,005	13
14	21	Clerical and General Office	Resident Days	1,527,029	77	2,830,968	2,420,380	19,669	36,464	14
15	23	Inservice Training & Education	Resident Days	1,527,029	77	20,336	0	19,669	262	15
16	24	Travel and Seminar	Resident Days	1,527,029	77	2,344	0	19,669	30	16
17	25	Other Admin. Staff Transport.	Resident Days	1,527,029	77	254,752	0	19,669	3,281	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,527,029	77	42,233	0	19,669	544	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,527,029	77	1,155,252	0	19,669	14,880	19
20	30	Depreciation	Resident Days	1,527,029	77	327,648	0	19,669	4,220	20
21	32	Interest	Resident Days	1,527,029	77	377,597	0	19,669	4,864	21
22	33	Real Estate Taxes	Resident Days	1,527,029	77	40,405	0	19,669	520	22
23	34	Rent-Facility and Grounds	Resident Days	1,527,029	77	0	0	19,669	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,527,029	77	39,061	0	19,669	503	24
25	TOTALS					\$ 11,193,551	\$ 7,982,443		\$ 129,576	25

Facility Name & ID Number Lebanon Care Center# 0050609

Report Period Beginning:

1/1/2010Ending: 2/31/2010

## VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization

Petersen Health Network, LLC

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	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	196,542	12	\$	\$	19,669	\$	1
2	2	Food	Resident Days	196,542	12			19,669		2
3	3	Housekeeping	Resident Days	196,542	12			19,669		3
4	4	Laundry	Resident Days	196,542	12			19,669		4
5	5	Utilities	Resident Days	196,542	12			19,669		5
6	6	Maintenance	Resident Days	196,542	12			19,669		6
7	7	Mgmt. Allocation of Benefits	Resident Days	196,542	12			19,669		7
8	10	Nursing and Medical Records	Resident Days	196,542	12			19,669		8
9	10A	Therapy	Resident Days	196,542	12			19,669		9
10	15	Mgmt. Allocation of Benefits	Resident Days	196,542	12			19,669		10
11	17	Administrative	Resident Days	196,542	12			19,669		11
12	19	Professional Services	Resident Days	196,542	12	10,985		19,669	1,099	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	196,542	12	8,001		19,669	801	13
14	21	Clerical and General Office	Resident Days	196,542	12	4,389		19,669	439	14
15	22	Employee Benefits & Payroll	Resident Days	196,542	12	35,000		19,669	3,503	15
16	24	Travel and Seminar	Resident Days	196,542	12			19,669		16
17	25	Other Admin. Staff Transport.	Resident Days	196,542	12			19,669		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	196,542	12			19,669		18
19	27	Mgmt. Allocation of Benefits	Resident Days	196,542	12			19,669		19
20	30	Depreciation	Resident Days	196,542	12			19,669		20
21	32	Interest	Resident Days	196,542	12	183,276		19,669	18,341	21
22	33	Real Estate Taxes	Resident Days	196,542	12			19,669		22
23	34	Rent-Facility and Grounds	Resident Days	196,542	12			19,669		23
24	35	Rent-Equipment & Vehicles	Resident Days	196,542	12			19,669		24
25	TOTALS					\$ 241,651	\$		\$ 24,183	25

Facility Name & ID Number

Lebanon Care Center

# 0050609

Report Period Beginning:

1/1/2010

Ending:

12/31/2010

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	2	3	4	5	6	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																			
<b>Long-Term</b>																			
1	The Private Bank		X	Mortgage	Varies	10/31/09	1,917,567	\$ 1,882,190	11/1/14	Varies	\$ 130,753	1							
2												2							
3							Interest Income Offset				(875)	3							
4							Home Office Allocation-PHC				4,864	4							
5							Home Office Allocation-PHN				18,341	5							
<b>Working Capital</b>																			
6												6							
7												7							
8												8							
9	<b>TOTAL Facility Related</b>						\$ 1,917,567	\$ 1,882,190			\$ 153,083	9							
<b>B. Non-Facility Related*</b>																			
10												10							
11												11							
12												12							
13												13							
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14							
15	<b>TOTALS (line 9+line14)</b>						\$ 1,917,567	\$ 1,882,190			\$ 153,083	15							

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

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

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

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

**B. Real Estate Taxes**

**Important, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.**

1. Real Estate Tax accrual used on 2009 report.		\$	<b>56,500</b>	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	\$	<b>57,552</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>1,052</b>	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>59,280</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	<b>520</b>	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>60,852</b>	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2005	_____	8	
	2006	_____	9	
	2007	<b>53,815</b>	10	
	2008	<b>54,797</b>	11	
	2009	<b>57,552</b>	12	
<b>Accrual based on prior year tax bill.</b>				
<b>FOR BHF USE ONLY</b>				
	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.**



Facility Name & ID Number Lebanon Care Center

# 0050609 Report Period Beginning:

1/1/2010 Ending:

12/31/2010

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 31,919 B. General Construction Type: Exterior Brick Frame Concrete & Steel Number of Stories 1

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

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

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

N/A

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

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

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

**XI. OWNERSHIP COSTS:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>17,240</u>	<u>2007</u>	<u>\$ 100,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>17,240</b>		<b>\$ 100,000</b>	<b>3</b>



Facility Name & ID Number Lebanon Care Center

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	90	2007	1986	\$ 1,425,000	\$	25	\$ 57,000	\$ 57,000	\$ 199,500	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Original Land Improvements		2007	15,000		15	1,000	1,000	3,500	9
10	Lobby Carpet		2007	2,050		7	293	293	1,026	10
11	Facility Sign		2007	640		7	91	91	319	11
12	Wood Blinds		2007	1,158		7	165	165	578	12
13	Cable Equipment Installation		2009	7,264		7	1,038	1,038	1,557	13
14	Generator Repair		2010	3,400		7	243	243	243	14
15	Fabrication work		2010	107,400		20	2,685	2,685	2,685	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	Land Improvements Booked				1,000			(1,000)		30
31	Building Booked				57,000			(57,000)		31
32	Building Improvement Booked				2,521			(2,521)		32
33										33
34	2010-Home Office Allocation-Building Improvements			9,454			227	227		34
35	2010-Home Office Allocation-Land Improvements			883			49	49		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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 1,572,249	\$ 60,521		\$ 62,791	\$ 2,270	\$ 209,408	70

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

Facility Name & ID Number Lebanon Care Center

# 0050609

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	\$ 293,842	\$ 41,977	\$ 29,384	\$ (12,593)	10 yrs.	\$ 101,783	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Home Office Allocation			3,944	3,944			74
75	TOTALS	\$ 293,842	\$ 41,977	\$ 33,328	\$ (8,649)		\$ 101,783	75

D. Vehicle Depreciation (See instructions.)\*

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

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,966,091	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 102,498	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 96,119	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (6,379)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 311,191	85

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

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

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.  YES  NO

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

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

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

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 7,494 Description: See Attached Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2009 Ford E150	\$ 538.52	\$ 6,462	17
18					18
19					19
20					20
21	TOTAL		\$ 538.52	\$ 6,462	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_ /2011 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2012 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2013 \$ \_\_\_\_\_

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

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

Lebanon Care Center  
0050609

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

Schedule 14A

**XII. Rental Costs**

**B. Equipment**

**16. Description of rental amount for movable equipment**

Medical Equipment	\$	3,594
Dishwasher		708
Copier		2,689
Home Office Allocation		503
		<u>7,494</u>

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**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**

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	10,129	\$ 151,930	\$	10,129	\$ 151,930	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2,793	41,892		2,793	41,892	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		12,132	181,985		12,132	181,985	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 prescripts				45,133		45,133	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	<b>TOTAL</b>			\$	25,054	\$ 375,807	\$ 45,133	25,054	\$ 420,940	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 Lebanon Care Center# 0050609Report Period Beginning: 1/1/2010Ending: 12/31/2010

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2010

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 912,968	\$ 912,968	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>60,000</u> )	547,025	547,025	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	23,494	23,494	6
7	Other Prepaid Expenses	28,531	28,531	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,512,018	\$ 1,512,018	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	115,000	100,000	13
14	Buildings, at Historical Cost	1,425,000	1,434,454	14
15	Leasehold Improvements, at Historical Cost	121,912	137,795	15
16	Equipment, at Historical Cost	293,842	293,842	16
17	Accumulated Depreciation (book methods)	(346,300)	(311,191)	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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,609,454	\$ 1,654,900	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,121,472	\$ 3,166,918	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 552,984	\$ 552,984	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	64,779	64,779	30
31	Accrued Taxes Payable (excluding real estate taxes)	18,065	18,065	31
32	Accrued Real Estate Taxes(Sch.IX-B)	59,280	59,280	32
33	Accrued Interest Payable	11,976	11,976	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Payroll Withholdings</u>	16,805	16,805	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 723,889	\$ 723,889	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,882,190	1,882,190	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 1,882,190	\$ 1,882,190	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,606,079	\$ 2,606,079	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 515,393	\$ 560,839	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,121,472	\$ 3,166,918	48

\*(See instructions.)



**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>305,830</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Rounding</b>	<b>1</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>305,831</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>209,562</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>209,562</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>515,393</b>	<b>24</b> *

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

Facility Name & ID Number Lebanon Care Center# 0050609Report Period Beginning: 1/1/2010Ending: 12/31/2010

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,246,775	1
2	Discounts and Allowances for all Levels	(72,601)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 2,174,174</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	533,445	6
7	Oxygen	121	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 533,566</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
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	1,634	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	72,902	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	4,266	20
21	Other Medical Services	4,538	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 83,340</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	875	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 875</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Miscellaneous Revenue</u>	50	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 50</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 2,792,005</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	512,426	31
32	Health Care	1,236,680	32
33	General Administration	400,233	33
<b>B. Capital Expense</b>			
34	Ownership	308,763	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	75,066	35
36	Provider Participation Fee	49,275	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 2,582,443</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>209,562</b>	<b>41</b>
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 209,562</b>	<b>43</b>

\* 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 **Lebanon Care Center**

# **0050609**

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	1,789	1,805	\$ 55,513	\$ 30.76	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,739	1,739	40,074	23.04	3
4	Licensed Practical Nurses	13,872	14,219	269,307	18.94	4
5	CNAs & Orderlies	33,288	33,441	337,640	10.10	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,542	1,723	18,090	10.50	9
10	Activity Assistants					10
11	Social Service Workers	2,080	2,080	25,335	12.18	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	21,113	10.15	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,996	10,397	95,993	9.23	15
16	Dishwashers					16
17	Maintenance Workers	2,080	2,120	32,425	15.29	17
18	Housekeepers	9,463	9,553	80,828	8.46	18
19	Laundry	2,377	2,436	26,242	10.77	19
20	Administrator	1,253	1,860	49,327	26.52	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,048	2,048	28,673	14.00	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Sch 20A</u>	2,655	2,655	53,664	20.21	33
34	TOTAL (lines 1 - 33)	86,262	88,156	\$ 1,134,224 *	\$ 12.87	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	22	\$ 1,150	1(3)	35
36	Medical Director	Monthly	4,800	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,002	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)	22	\$ 8,952		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

**Lebanon Care Center**

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

**Schedule 20A**

**XVIII. Staffing and Salary Costs**

	<b># of Hrs. Actually Worked</b>	<b># of Hrs. Paid and Accrued</b>	<b>Reporting Period Total Salaries, Wages</b>	<b>Average Hourly Wage</b>
<b>Care Plan Coordinator</b>	2,205	2,205	48,948	22.20
<b>Restorative Aide</b>	450	450	4,716	10.48
<b>TOTAL</b>	<u>2,655</u>	<u>2,655</u>	<u>53,664</u>	

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Terri Rumler	Administrator	0	\$ 37,660	Workers' Compensation Insurance	\$ 35,363	IDPH License Fee	\$ 2,372	
Beverly Goodman	Administrator	0	11,667	Unemployment Compensation Insurance	30,039	Advertising: Employee Recruitment	5,098	
				FICA Taxes	81,261	Health Care Worker Background Check (Indicate # of checks performed )		
				Employee Health Insurance	32,722	Patient Background Checks	164	
				Employee Meals		Miscellaneous Licenses & Permits	378	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Dues & Subscriptions	259	
				Employee Relations	4,702	IHCA Dues	1,200	
						Home Office Allocation	1,806	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 49,327			Less: Public Relations Expense	(225)	
B. Administrative - Other						Non-allowable advertising	( )	
Description			Amount			Yellow page advertising	( )	
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 123,000					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 123,000	TOTAL (agree to Schedule V, line 22, col.8)	\$ 184,087	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 12,528	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
E-Health Data Solutions	Computer Services		\$ 3,420				Out-of-State Travel	\$
AT&T	Computer Services		480					
Heyl, Royster, Voelker & Allen	Legal Services		2,109	N/A			In-State Travel	
							Seminar Expense	
							Home Office Allocation	30
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 6,009	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 30

\* Attach copy of IMRF notifications

\*\*See instructions.

**Lebanon Care Center**

**0050609**

**Period Beginning 1/1/2010**

**Period End 12/31/2010**

**Schedule 21A**

**XIX. SUPPORT SCHEDULE**

**C. Professional Services**

<b>Vendor/Payee</b>	<b>Type</b>	<b>Amount</b>
Total (agree to Schedule V, line 19, column 3)		6,009

**Home Office Allocation**

Heyl, Royster, Voelker & Allen	Legal	4
Healthcare Resources International	Legal	50
Ginoli & Company	Accountants	1,817
Bank of America	Accountants	158
Miscellaneous Vendors	Computer Services	23
VisionShare	Computer Services	216
Advanced Answers on Demand	Computer Services	1,357
Access 2 Go	Computer Services	221
Kemper Technology	Computer Services	187
MediFax	Computer Services	77
LogmeIn	Computer Services	55
Simple LTC	Computer Services	865
Optimizer Systems	Other Professional I	31
Clifton Gunderson	Other Professional I	97
Total (agree to Schedule V, line 19, column 8)		<u>11,167</u>



Facility Name & ID Number Lebanon Care Center# 0050609Report Period Beginning: 1/1/2010Ending: 12/31/2010**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. 1,200 IHCA
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? N/A
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 656 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. \$ 49,275  
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. \$ 1,634
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 0  
c. What percent of all travel expense relates to transportation of nurses and patients? N/A  
d. Have vehicle usage logs been maintained? Adequate records have been maintained.  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
**g. Does the facility transport residents to and from day training? N/A**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? 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.