FOR BHF USE

LL1

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.

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

I. IDPH License ID Number: 0047506

Facility Name: Newman Rehabilitation & Health Care Center

Address: 418 South Memorial Park Drive (Number) Newman (City) 61942 (Zip Code)

County: Douglas

Telephone Number: (217) 837-2421 **Fax #** (217) 837-2631

HFS ID Number:

Date of Initial License for Current Owners: 10/1/2005

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

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

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

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

Facility Name & ID Number Newman Rehabilitation & Health Care Center # 0047506 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	60	Skilled (SNF)	60	21,900	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	60	TOTALS	60	21,900	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	9,664	4,590	1,583	15,837	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,664	4,590	1,583	15,837	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.32%

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 10/1/2005

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/1/2005 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 60 and days of care provided 1,200

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 Newman Rehabilitation & Health Care Cente # 0047506 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	108,444	9,233		117,677		117,677	2,950	120,627			1
2	Food Purchase		83,994		83,994		83,994	(1,228)	82,766			2
3	Housekeeping	84,442	16,399		100,841		100,841	35	100,876			3
4	Laundry	16,069	16,810		32,879		32,879		32,879			4
5	Heat and Other Utilities			64,726	64,726		64,726	293	65,019			5
6	Maintenance	35,970	9,054	19,072	64,096		64,096	1,717	65,813			6
7	Other (specify):* Home Off. Ben. All.							691	691			7
8	TOTAL General Services	244,925	135,490	83,798	464,213		464,213	4,458	468,671			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	678,370	43,978	16,912	739,260		739,260	45	739,305			10
10a	Therapy		45	222,946	222,991		222,991		222,991			10a
11	Activities	33,094	60	13	33,167		33,167	(511)	32,656			11
12	Social Services	24,825			24,825		24,825		24,825			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Off. Ben. All.											15
16	TOTAL Health Care and Programs	736,289	44,083	251,871	1,032,243		1,032,243	(466)	1,031,777			16
	C. General Administration											
17	Administrative			164,000	164,000		164,000	(119,488)	44,512			17
18	Directors Fees											18
19	Professional Services			43,187	43,187		43,187	3,967	47,154			19
20	Dues, Fees, Subscriptions & Promotions			6,539	6,539		6,539	1,481	8,020			20
21	Clerical & General Office Expenses	27,536	2,840	4,981	35,357		35,357	30,320	65,677			21
22	Employee Benefits & Payroll Taxes			145,434	145,434		145,434	2,554	147,988			22
23	Inservice Training & Education							211	211			23
24	Travel and Seminar							24	24			24
25	Other Admin. Staff Transportation			3,667	3,667		3,667	2,642	6,309			25
26	Insurance-Prop.Liab.Malpractice			29,737	29,737		29,737	438	30,175			26
27	Other (specify):* Home Off. Ben. All.							11,981	11,981			27
28	TOTAL General Administration	27,536	2,840	397,545	427,921		427,921	(65,870)	362,051			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,008,750	182,413	733,214	1,924,377		1,924,377	(61,878)	1,862,499			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 Newman Rehabilitation & Health Care Center #0047506 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			12,685	12,685		12,685	1,294	13,979			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			14,576	14,576		14,576	20,291	34,867			32
33	Real Estate Taxes			22,716	22,716		22,716	(525)	22,191			33
34	Rent-Facility & Grounds			206,517	206,517		206,517		206,517			34
35	Rent-Equipment & Vehicles			17,950	17,950		17,950	405	18,355			35
36	Other (specify):*											36
37	**TOTAL Ownership**			274,444	274,444		274,444	21,465	295,909			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		55,855		55,855		55,855		55,855			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			32,850	32,850		32,850		32,850			42
43	Other (specify):* Non-allowable Cost		200	106,663	106,863		106,863	(106,863)				43
44	**TOTAL Special Cost Centers**		56,055	139,513	195,568		195,568	(106,863)	88,705			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,008,750	238,468	1,147,171	2,394,389		2,394,389	(147,276)	2,247,113			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 Newman Rehabilitation & Health Care Center # 0047506 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,228)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,619)	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	(2,885)	30		9
10	Interest and Other Investment Income	(913)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(77)	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	(14,788)	43		18
19	Entertainment				19
20	Contributions	(163)	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	(78,947)	43		24
25	Fund Raising, Advertising and Promotional	(2,212)	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	(9,867)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (113,699)		$	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)	(33,577)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (33,577)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (147,276)		37

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

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

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

STATE OF ILLINOIS

Newman Rehabilitation & Health Care Center

ID# 0047506

Report Period Beginning: 1/1/2010

Ending: 12/31/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs-Part A	$ (2,057)	43	1
2	X-Rays-Part A	(5,194)	43	2
3	Disallow Real Estate Tax penalty	(944)	33	3
4	Offset Miscellaneous Office Supplies Revenue	(355)	21	4
5	Resident Flower	(424)	43	5
6	Disallowed Special Events	(382)	43	6
7	Offset Transportation Revenue	(511)	11	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(9,867)		49

Facility Name & ID Number Newman Rehabilitation & Health Care Center # 0047506 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%	$ 2,950	$ 2,950	1
2	V	2	Food		Petersen Health Care, Inc.	100.00%	0		2
3	V	3	Housekeeping		Petersen Health Care, Inc.	100.00%	35	35	3
4	V	4	Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5	Utilities		Petersen Health Care, Inc.	100.00%	293	293	5
6	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	1,717	1,717	6
7	V	7	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	691	691	7
8	V	10	Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	45	45	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	164,000	Petersen Health Care, Inc.	100.00%	44,512	(119,488)	11
12	V	19	Professional Services		Petersen Health Care, Inc.	100.00%	3,269	3,269	12
13	V								13
14	Total			$ 164,000			$ 53,512	$ * (110,488)	14

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

Facility Name & ID Number Newman Rehabilitation & Health Care Center # 0047506 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 & Promotions	$	Petersen Health Care, Inc.	100.00%	$ 809	$ 809	15
16	V	21	Clerical and General Office		Petersen Health Care, Inc.	100.00%	29,360	29,360	16
17	V	23	Inservice Training & Education		Petersen Health Care, Inc.	100.00%	211	211	17
18	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	24	24	18
19	V	25	Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	2,642	2,642	19
20	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	438	438	20
21	V	27	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	11,981	11,981	21
22	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	3,398	3,398	22
23	V	32	Interest		Petersen Health Care, Inc.	100.00%	3,916	3,916	23
24	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	419	419	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%	405	405	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			$			$ 53,603	$ * 53,603	39

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

Facility Name & ID Number Newman Rehabilitation & Health Care Center # 0047506 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Petersen Health Operations, LLC	100.00%	$ 0	$	15
16	V	2	Food		Petersen Health Operations, LLC	100.00%	0		16
17	V	3	Housekeeping		Petersen Health Operations, LLC	100.00%	0		17
18	V	4	Laundry		Petersen Health Operations, LLC	100.00%	0		18
19	V	5	Utilities		Petersen Health Operations, LLC	100.00%	0		19
20	V	6	Maintenance		Petersen Health Operations, LLC	100.00%	0		20
21	V	7	Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	0		21
22	V	10	Nursing and Medical Records		Petersen Health Operations, LLC	100.00%	0		22
23	V	12	Social Services		Petersen Health Operations, LLC	100.00%	0		23
24	V	17	Administrative		Petersen Health Operations, LLC	100.00%	0		24
25	V	19	Professional Services		Petersen Health Operations, LLC	100.00%	698	698	25
26	V	20	Dues, Fees, Subs & Promotions		Petersen Health Operations, LLC	100.00%	672	672	26
27	V	21	Clerical and General Office		Petersen Health Operations, LLC	100.00%	1,315	1,315	27
28	V	22	Employee Benefits & Payroll		Petersen Health Operations, LLC	100.00%	2,554	2,554	28
29	V	23	Inservice Training & Education		Petersen Health Operations, LLC	100.00%	0		29
30	V	24	Travel and Seminar		Petersen Health Operations, LLC	100.00%	0		30
31	V	25	Other Admin. Staff Transport.		Petersen Health Operations, LLC	100.00%	0		31
32	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Operations, LLC	100.00%	0		32
33	V	27	Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	0		33
34	V	30	Depreciation		Petersen Health Operations, LLC	100.00%	781	781	34
35	V	32	Interest		Petersen Health Operations, LLC	100.00%	17,288	17,288	35
36	V	33	Real Estate Taxes		Petersen Health Operations, LLC	100.00%	0		36
37	V	34	Rent-Facility and Grounds		Petersen Health Operations, LLC	100.00%	0		37
38	V	35	Rent-Equipment & Vehicles		Petersen Health Operations, LLC	100.00%	0		38
39	Total			$			$ 23,308	$ * 23,308	39

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

Facility Name & ID Number Newman Rehabilitation & Health Care Cent # 0047506 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	180,238	0.61	1.01	Salary	$ 2,012	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	$ 2,012		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 Newman Rehabilitation & Health Care Center # 0047506 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	15,837	$ 2,950	1
2	2	Food	Resident Days	1,527,029	77	0	0	15,837	0	2
3	3	Housekeeping	Resident Days	1,527,029	77	3,369	0	15,837	35	3
4	4	Laundry	Resident Days	1,527,029	77	0	0	15,837	0	4
5	5	Utilities	Resident Days	1,527,029	77	28,267	0	15,837	293	5
6	6	Maintenance	Resident Days	1,527,029	77	165,545	121,901	15,837	1,717	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,527,029	77	66,650	0	15,837	691	7
8	10	Nursing and Medical Records	Resident Days	1,527,029	77	4,339	0	15,837	45	8
9	10A	Therapy	Resident Days	1,527,029	77	0	0	15,837	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,527,029	77	0	0	15,837	0	10
11	17	Administrative	Resident Days	1,527,029	77	5,157,152	5,157,152	15,837	44,512	11
12	19	Professional Services	Resident Days	1,527,029	77	315,156	0	15,837	3,269	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,527,029	77	78,050	0	15,837	809	13
14	21	Clerical and General Office	Resident Days	1,527,029	77	2,830,968	2,420,380	15,837	29,360	14
15	23	Inservice Training & Education	Resident Days	1,527,029	77	20,336	0	15,837	211	15
16	24	Travel and Seminar	Resident Days	1,527,029	77	2,344	0	15,837	24	16
17	25	Other Admin. Staff Transport.	Resident Days	1,527,029	77	254,752	0	15,837	2,642	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,527,029	77	42,233	0	15,837	438	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,527,029	77	1,155,252	0	15,837	11,981	19
20	30	Depreciation	Resident Days	1,527,029	77	327,648	0	15,837	3,398	20
21	32	Interest	Resident Days	1,527,029	77	377,597	0	15,837	3,916	21
22	33	Real Estate Taxes	Resident Days	1,527,029	77	40,405	0	15,837	419	22
23	34	Rent-Facility and Grounds	Resident Days	1,527,029	77	0	0	15,837	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,527,029	77	39,061	0	15,837	405	24
25	TOTALS					$ 11,193,551	$ 7,982,443		$ 107,115	25

Facility Name & ID Number Newman Rehabilitation & Health Care Center # 0047506 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 Operations, LLC
Street Address: 830 W. Trailcreek Drive
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 691-8113
Fax Number: (309) 691-8622

	1 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	389,552	21	$	$	15,837	$	1
2	2	Food	Resident Days	389,552	21			15,837		2
3	3	Housekeeping	Resident Days	389,552	21			15,837		3
4	4	Laundry	Resident Days	389,552	21			15,837		4
5	5	Utilities	Resident Days	389,552	21			15,837		5
6	6	Maintenance	Resident Days	389,552	21			15,837		6
7	7	Mgmt. Allocation of Benefits	Resident Days	389,552	21			15,837		7
8	10	Nursing and Medical Records	Resident Days	389,552	21			15,837		8
9	12	Social Services	Resident Days	389,552	21			15,837		9
10	17	Administrative	Resident Days	389,552	21			15,837		10
11	19	Professional Services	Resident Days	389,552	21	17,164		15,837	698	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	389,552	21	16,534		15,837	672	12
13	21	Clerical and General Office	Resident Days	389,552	21	32,356		15,837	1,315	13
14	22	Employee Benefits & Payroll	Resident Days	389,552	21	62,830		15,837	2,554	14
15	23	Inservice Training & Education	Resident Days	389,552	21			15,837		15
16	24	Travel and Seminar	Resident Days	389,552	21			15,837		16
17	25	Other Admin. Staff Transport.	Resident Days	389,552	21			15,837		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	389,552	21			15,837		18
19	27	Mgmt. Allocation of Benefits	Resident Days	389,552	21			15,837		19
20	30	Depreciation	Resident Days	389,552	21	19,207		15,837	781	20
21	32	Interest	Resident Days	389,552	21	425,239		15,837	17,288	21
22	33	Real Estate Taxes	Resident Days	389,552	21			15,837		22
23	34	Rent-Facility and Grounds	Resident Days	389,552	21			15,837		23
24	35	Rent-Equipment & Vehicles	Resident Days	389,552	21			15,837		24
25	TOTALS					$ 573,330	$		$ 23,308	25

Facility Name & ID Number Newman Rehabilitation & Health Care Cente # 0047506 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	1/19/07	$ 300,000	$ 287,222	12/31/13	Varies	$ 14,576	1
2												2
3							Interest Income Offset				(913)	3
4							Home Office Allocation-PHC				3,916	4
5							Home Office Allocation-PHO				17,288	5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 300,000	$ 287,222			$ 34,867	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 300,000	$ 287,222			$ 34,867	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 Newman Rehabilitation & Health Care Center **#** 0047506 **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.**		$ 20,400	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	$ 20,752	2
3. Under or (over) accrual (line 2 minus line 1).		$ 352	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 21,420	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**		419	
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.		$ 22,191	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005	19,096	8
2006	19,531	9
2007	18,975	10
2008	19,815	11
2009	20,752	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 Newman Rehabilitation & Health Care Center COUNTY Douglas

FACILITY IDPH LICENSE NUMBER 0047506

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.	07-06-31-400-012	Long-Term Care Facility	$ 20,752.62	$ 20,752.62
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 20,752.62	$ 20,752.62

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 Newman Rehabilitation & Health Care Center # 0047506 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 20,206 B. General Construction Type: Exterior Brick Frame Protected Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (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	20,206	2005	$	1
2					2
3	TOTALS	20,206		$	3

Facility Name & ID Number Newman Rehabilitation & Health Care Center # 0047506 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					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Sidewalks			2006	5,535		8	692	692	3,114	9
10	2 Rooftop A/C			2006	11,726		5	2,345	2,345	10,553	10
11	Roof			2007	43,864		20	2,193	2,193	7,676	11
12	Water Heater			2007	25,462		10	2,546	2,546	8,911	12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30	Land Improvements Booked					369			(369)		30
31	Building Improvement Booked					9,192			(9,192)		31
32											32
33											33
34	2010-Home Office Allocation-Building Improvements				7,612			183	183		34
35	2010-Home Office Allocation-Land Improvements				711			39	39		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 Newman Rehabilitation & Health Care Center # 0047506 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 94,910	$ 9,561		$ 7,998	$ (1,563)	$ 30,254	70

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

Facility Name & ID Number Newman Rehabilitation & Health Care Center # 0047506 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	$ 13,892	$ 2,385	$ 1,727	$ (658)	5-10 yrs.	$ 4,264	71
72	Current Year Purchases	5,942	739	297	(442)	10 yrs.	297	72
73	Fully Depreciated Assets	7,000					7,000	73
74	Home Office Allocation			3,957	3,957			74
75	TOTALS	$ 26,834	$ 3,124	$ 5,981	$ 2,857		$ 11,561	75

D. Vehicle Depreciation (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 121,744	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 12,685	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 13,979	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 1,294	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 41,815	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 Newman Rehabilitation & Health Care Center # 0047506 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: Springwood Associates Limited Partnership
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:		60	12/1/1992	$ 206,517	10	N/A	3
4	Additions							4
5								5
6								6
7	TOTAL		60		$ 206,517 **			7

10. Effective dates of current rental agreement:
    Beginning 12/1/1992
    Ending 10/1/18

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

	Fiscal Year Ending	Annual Rent
12.	12/31/2011	$ 202,794
13.	12/31/2012	$ 202,794
14.	12/31/2013	$ 202,794

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: $ 11,417 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	$ 578.17	$ 6,938	17
18					18
19					19
20					20
21	TOTAL		$ 578.17	$ 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.

Newman Rehabilitation & Health Care Center
0047506
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	$	5,460
Dishwasher		708
Copier		4,844
Home Office Allocation		405
		11,417

Facility Name & ID Number Newman Rehabilitation & Health Care Center # 0047506 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 Newman Rehabilitation & Health Care Center # 0047506 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(3)	hrs	$	7,091	$ 106,372	$	7,091	$ 106,372	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		171	2,569		171	2,569	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		7,600	114,005	45	7,600	114,050	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				55,855		55,855	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$	14,862	$ 222,946	$ 55,900	14,862	$ 278,846	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 Newman Rehabilitation & Health Care Center # 0047506 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	$ 1,891,061	$ 1,891,061	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance N/A)	122,803	122,803	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	20,166	20,166	6
7	Other Prepaid Expenses	13,621	13,621	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Prepaid lease	42,751	42,751	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,090,402	$ 2,090,402	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	5,535		13
14	Buildings, at Historical Cost		7,612	14
15	Leasehold Improvements, at Historical Cost	81,052	87,298	15
16	Equipment, at Historical Cost	26,834	26,834	16
17	Accumulated Depreciation (book methods)	(49,627)	(41,815)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 63,794	$ 79,929	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,154,196	$ 2,170,331	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 418,866	$ 418,866	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	18,613	18,613	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,381	10,381	31
32	Accrued Real Estate Taxes(Sch.IX-B)	21,420	21,420	32
33	Accrued Interest Payable	1,288	1,288	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	16,639	16,639	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 487,207	$ 487,207	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	287,222	287,222	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 287,222	$ 287,222	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 774,429	$ 774,429	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,379,767	$ 1,395,902	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,154,196	$ 2,170,331	48

*(See instructions.)

Facility Name & ID Number Newman Rehabilitation & Health Care Center # 0047506 **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**	$ 1,247,731	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,247,731	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	132,036	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)**	$ 132,036	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)**	$ 1,379,767	24 *

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

Facility Name & ID Number Newman Rehabilitation & Health Care Center # 0047506 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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

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

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,233,731	1
2	Discounts and Allowances for all Levels	(147,551)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,086,180	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	337,042	6
7	Oxygen	3,467	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 340,509	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,228	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	87,251	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	5,780	20
21	Other Medical Services	3,698	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 97,957	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	913	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 913	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	355	28
28a	Transportation Revenue	511	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 866	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,526,425	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	464,213	31
32	Health Care	1,032,243	32
33	General Administration	427,921	33
	B. Capital Expense		
34	Ownership	274,444	34
	C. Ancillary Expense		
35	Special Cost Centers	162,718	35
36	Provider Participation Fee	32,850	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,394,389	40
41	**Income before Income Taxes (line 30 minus line 40)****	132,036	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 132,036	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 Newman Rehabilitation & Health Care Center # 0047506 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	2,003	2,003	$ 55,682	$ 27.80	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,591	2,663	66,720	25.05	3
4	Licensed Practical Nurses	8,944	9,421	183,510	19.48	4
5	CNAs & Orderlies	29,599	30,946	311,417	10.06	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,837	2,091	25,693	12.29	9
10	Activity Assistants	899	899	7,401	8.23	10
11	Social Service Workers	2,080	2,080	24,825	11.94	11
12	Dietician					12
13	Food Service Supervisor	1,841	2,061	29,593	14.36	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,362	9,688	78,851	8.14	15
16	Dishwashers					16
17	Maintenance Workers	1,961	2,095	35,970	17.17	17
18	Housekeepers	8,931	9,467	84,442	8.92	18
19	Laundry	1,795	1,949	16,069	8.24	19
20	Administrator	2,080	2,080	42,500	20.43	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,794	2,008	27,536	13.71	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	1,877	2,052	24,624	12.00	31
32	Other Health Care(specify)					32
33	Other(specify) Care Plan Coord	1,692	1,716	36,417	21.22	33
34	TOTAL (lines 1 - 33)	79,286	83,219	$ 1,051,250 *	$ 12.63	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	2,289	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)		$ 14,289		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	112	3,788	10(3)	51
52	Certified Nurse Assistants/Aides	573	11,100	10(3)	52
53	TOTAL (lines 50 - 52)	684	$ 14,888		53

Newman Rehabilitation & Health Care Center

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

Schedule 20A

XVIII. Staffing and Salary Costs

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

Facility Name & ID Number Newman Rehabilitation & Health Care Center # 0047506 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Joshua Drake	Administrator	0	$ 42,500
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 42,500

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 164,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 164,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
E-Health Data Solutions	Computer Services	$ 3,420
Mitigation Solution	Computer Services	1,063
Glover Court Report Service	Legal Services	591
Cellular One	Computer Services	959
Heyl, Royster, Voelker & Allen	Reversal of 2009 Fees	(20,668)
Heyl, Royster, Voelker & Allen	Legal Services	53,097
Frank Harfort, MD	Legal Services	4,725
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 43,187

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 22,534
Unemployment Compensation Insurance	19,644
FICA Taxes	74,947
Employee Health Insurance	24,754
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	4,224
Employee Retirement	1,366
Life Insurance	489
TOTAL (agree to Schedule V, line 22, col.8)	$ 147,958

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

Description	Line #	Amount
		$
N/A		
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	1,781
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks 141	1,410
Miscellaneous Licenses & Permits	558
Miscellaneous Dues & Subscriptions	0
IHCA Dues	800
Home Office Allocation	1,481
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,020

G. Schedule of Travel and Seminar**

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

**See instructions.

Newman Rehabilitation & Health Care Center
0047506
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)		43,187
Home Office Allocation		
Heyl, Royster, Voelker & Allen	Legal	3
Healthcare Resources International	Legal	40
Ginoli & Company	Accountants	1,276
Bank of America	Accountants	127
Miscellaneous Vendors	Computer Services	19
VisionShare	Computer Services	174
Advanced Answers on Demand	Computer Services	1,093
Access 2 Go	Computer Services	178
Kemper Technology	Computer Services	151
MediFax	Computer Services	62
Logmeln	Computer Services	44
Simple LTC	Computer Services	697
Optimizer Systems	Other Professional I	25
Clifton Gunderson	Other Professional I	78
Total (agree to Schedule V, line 19, column 8)		47,154

Newman Rehabilitation & Health Care Center
0047506
Period Beginning **1/1/2010**
Period End **12/31/2010**

Schedule 21B

XIX. SUPPORT SCHEDULE
Legal Fees

Facility

Vendor/Payee	Invoice Total	Allocation %	Total
Heyl, Royster, Voelker, and Allen	18,161.09	100%	18,161
Mitigation Solution	1,062.50	100%	1,063
Heyl, Royster, Voelker, and Allen	17,855.50	100%	17,856
Glover Court Report Service	590.75	100%	591
Heyl, Royster, Voelker, and Allen	2,150.83	100%	2,151
Heyl, Royster, Voelker, and Allen	14,930.05	100%	14,930
Frank J. Harford	2,275.00	100%	2,275
Frank J. Harford	2,450.00	100%	2,450
Heyl, Royster, Voelker, and Allen			(20,668)
Home Office Allocation			
Heyl, Royster, Voelker, and Allen	300.00	1.00%	3
Healthcare Resources International	4,000.00	1.00%	40
Total Legal Fees			38,851

Facility Name & ID Number Newman Rehabilitation & Health Care Center # 0047506 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 Newman Rehabilitation & Health Care Center # 0047506 **Report Period Beginning:** 1/1/2010 **Ending:** 12/31/2010

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **800 IHCA**

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **3,595** 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. $ **32,850**
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. $ **1,228**

(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. $ **511**
c. What percent of all travel expense relates to transportation of nurses and patients? **100**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? **N/A**
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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

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