

		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>0047563</u></p> <p><b>Facility Name:</b> <u>Shelbyville Rehabilitation &amp; Health Care Center</u></p> <p><b>Address:</b> <u>2116 South 3rd &amp; Dacey Drive</u> <u>Shelbyville</u> <u>62565</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>Shelby</u></p> <p><b>Telephone Number:</b> <u>(217) 774-2138</u> <b>Fax #</b> <u>(217) 774-2317</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>10/1/05</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%"> <tr> <td style="width:33%"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%"><input checked="" type="checkbox"/> PROPRIETARY</td> <td style="width:33%"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></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 checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>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>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%"> <tr> <td style="width:20%; vertical-align: top;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) <u>Mark B. Petersen</u> (Title) <u>Chief Executive Officer</u></td> </tr> <tr> <td style="vertical-align: top;">Paid Preparer</td> <td>(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name &amp; Address) _____ (Telephone) <u>( )</u> Fax # ( )</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) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>( )</u> Fax # ( )
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																											
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																											
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Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>( )</u> Fax # ( )																												

Facility Name & ID Number Shelbyville Rehabilitation & Health Care Center

# 0047563 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	12	Skilled (SNF)	12	4,380	1
2		Skilled Pediatric (SNF/PED)			2
3	68	Intermediate (ICF)	68	24,820	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	80	TOTALS	80	29,200	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
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF			1,658	1,658	8
9	SNF/PED					9
10	ICF	9,327	3,222		12,549	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,327	3,222	1,658	14,207	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 48.65%

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

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

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

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

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

I. On what date did you start providing long term care at this location?  
Date started 10/1/2005

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

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 12 and days of care provided 1,650

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL  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 Shelbyville Rehabilitation & Health Care Cen # 0047563 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	112,371	11,881		124,252		124,252	2,646	126,898		1
2	Food Purchase		82,389		82,389		82,389	(2,518)	79,871		2
3	Housekeeping	51,063	8,048		59,111		59,111	31	59,142		3
4	Laundry	15,544	10,086		25,630		25,630		25,630		4
5	Heat and Other Utilities			63,514	63,514		63,514	263	63,777		5
6	Maintenance	26,735	8,478	12,744	47,957		47,957	1,540	49,497		6
7	Other (specify):* <u>Home Off. Ben. All.</u>							620	620		7
8	<b>TOTAL General Services</b>	205,713	120,882	76,258	402,853		402,853	2,582	405,435		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			13,500	13,500		13,500		13,500		9
10	Nursing and Medical Records	625,384	41,123	4,880	671,387		671,387	(758)	670,629		10
10a	Therapy		(24)	181,703	181,679		181,679		181,679		10a
11	Activities	25,427	559	(6)	25,980		25,980	(1,869)	24,111		11
12	Social Services	30,662	52		30,714		30,714		30,714		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Off. Ben. All.</u>										15
16	<b>TOTAL Health Care and Programs</b>	681,473	41,710	200,077	923,260		923,260	(2,627)	920,633		16
	<b>C. General Administration</b>										
17	Administrative			229,000	229,000		229,000	(124,586)	104,414		17
18	Directors Fees										18
19	Professional Services			3,748	3,748		3,748	3,558	7,306		19
20	Dues, Fees, Subscriptions & Promotions			7,655	7,655		7,655	639	8,294		20
21	Clerical & General Office Expenses	24,605	5,334	12,941	42,880		42,880	27,361	70,241		21
22	Employee Benefits & Payroll Taxes			113,588	113,588		113,588	2,291	115,879		22
23	Inservice Training & Education							189	189		23
24	Travel and Seminar							22	22		24
25	Other Admin. Staff Transportation			4,820	4,820		4,820	2,370	7,190		25
26	Insurance-Prop.Liab.Malpractice			30,837	30,837		30,837	393	31,230		26
27	Other (specify):* <u>Home Off. Ben. All.</u>							10,748	10,748		27
28	<b>TOTAL General Administration</b>	24,605	5,334	402,589	432,528		432,528	(77,015)	355,513		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	911,791	167,926	678,924	1,758,641		1,758,641	(77,060)	1,681,581		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 Shelbyville Rehabilitation & Health Care Center #0047563 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			69,246	69,246		69,246	3,021	72,267			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			19,651	19,651		19,651	18,153	37,804			32
33	Real Estate Taxes			30,432	30,432		30,432	(503)	29,929			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			22,875	22,875		22,875	363	23,238			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			142,204	142,204		142,204	21,034	163,238			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		40,451		40,451		40,451		40,451			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			43,800	43,800		43,800		43,800			42
43	Other (specify):* <b>Non-allowable Cost</b>	9,879	772	81,680	92,331		92,331	(92,331)				43
44	<b>TOTAL Special Cost Centers</b>	9,879	41,223	125,480	176,582		176,582	(92,331)	84,251			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	921,670	209,149	946,608	2,077,427		2,077,427	(148,357)	1,929,070			45

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



Shelbyville Rehabilitation & Health Care Center

ID# 0047563

Report Period Beginning: 1/1/2010

Ending: 12/31/2010

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Labs-Part A	\$ 2,646	43	1
2	X-Rays-Part A	(2,617)	43	2
3	Offset Miscellaneous Nursing Supplies Revenue	(798)	10	3
4	Offset Transportation Revenue	(1,869)	11	4
5	Offset Miscellaneous Office Supplies Revenue	(157)	21	5
6	Disallow Chamber of Commerce Dues	(690)	20	6
7	Disallowed Special Events	(1,198)	43	7
8	Resident Flowers	(59)	43	8
9	Disallow Real Estate Tax penalty	(879)	33	9
10	Disallowed Medicare Interest Withholding	(216)	32	10
11				11
12				12
13				13
14				14
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40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(5,837)		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%	\$ 2,646	\$ 2,646	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	0		2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	31	31	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	263	263	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	1,540	1,540	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	620	620	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	40	40	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	229,000	Petersen Health Care, Inc.	100.00%	104,414	(124,586)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	2,932	2,932	12
13	V							13
14	Total		\$ 229,000			\$ 112,486	\$ * (116,514)	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%	\$ 726	\$	726	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	26,338		26,338	16
17	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	189		189	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	22		22	18
19	V	25 Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	2,370		2,370	19
20	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	393		393	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	10,748		10,748	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	3,048		3,048	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	3,513		3,513	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	376		376	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%	363		363	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	<b>Total</b>		\$			\$ 48,086	\$ *	48,086	39

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



VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 Dietary	\$	Petersen Health Operations, LLC	100.00%	\$ 0	\$	15
16	V	2 Food		Petersen Health Operations, LLC	100.00%	0		16
17	V	3 Housekeeping		Petersen Health Operations, LLC	100.00%	0		17
18	V	4 Laundry		Petersen Health Operations, LLC	100.00%	0		18
19	V	5 Utilities		Petersen Health Operations, LLC	100.00%	0		19
20	V	6 Maintenance		Petersen Health Operations, LLC	100.00%	0		20
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	0		21
22	V	10 Nursing and Medical Records		Petersen Health Operations, LLC	100.00%	0		22
23	V	12 Social Services		Petersen Health Operations, LLC	100.00%	0		23
24	V	17 Administrative		Petersen Health Operations, LLC	100.00%	0		24
25	V	19 Professional Services		Petersen Health Operations, LLC	100.00%	626	626	25
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Operations, LLC	100.00%	603	603	26
27	V	21 Clerical and General Office		Petersen Health Operations, LLC	100.00%	1,180	1,180	27
28	V	22 Employee Benefits & Payroll		Petersen Health Operations, LLC	100.00%	2,291	2,291	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%	701	701	34
35	V	32 Interest		Petersen Health Operations, LLC	100.00%	15,509	15,509	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		\$			\$ 20,910	\$ * 20,910	39

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

Facility Name & ID Number Shelbyville Rehabilitation & Health Care Ce # 0047563 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Petersen	President	Administrative	100.00	180,445	0.54	0.90	Salary	\$ 1,805	L17, C7	1
2											2
3											3
4											4
5		See Attached Schedule 7A									5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 1,805		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 Shelbyville Rehabilitation & Health Care Center # 0047563 Report Period Beginning: 1/1/2010 Ending: 2/31/2010

## VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,527,029	77	\$ 284,427	\$ 283,010	14,207	\$ 2,646	1
2	2	Food	Resident Days	1,527,029	77	0	0	14,207	0	2
3	3	Housekeeping	Resident Days	1,527,029	77	3,369	0	14,207	31	3
4	4	Laundry	Resident Days	1,527,029	77	0	0	14,207	0	4
5	5	Utilities	Resident Days	1,527,029	77	28,267	0	14,207	263	5
6	6	Maintenance	Resident Days	1,527,029	77	165,545	121,901	14,207	1,540	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,527,029	77	66,650	0	14,207	620	7
8	10	Nursing and Medical Records	Resident Days	1,527,029	77	4,339	0	14,207	40	8
9	10A	Therapy	Resident Days	1,527,029	77	0	0	14,207	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,527,029	77	0	0	14,207	0	10
11	17	Administrative	Resident Days	1,527,029	77	5,157,152	5,157,152	14,207	104,414	11
12	19	Professional Services	Resident Days	1,527,029	77	315,156	0	14,207	2,932	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,527,029	77	78,050	0	14,207	726	13
14	21	Clerical and General Office	Resident Days	1,527,029	77	2,830,968	2,420,380	14,207	26,338	14
15	23	Inservice Training & Education	Resident Days	1,527,029	77	20,336	0	14,207	189	15
16	24	Travel and Seminar	Resident Days	1,527,029	77	2,344	0	14,207	22	16
17	25	Other Admin. Staff Transport.	Resident Days	1,527,029	77	254,752	0	14,207	2,370	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,527,029	77	42,233	0	14,207	393	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,527,029	77	1,155,252	0	14,207	10,748	19
20	30	Depreciation	Resident Days	1,527,029	77	327,648	0	14,207	3,048	20
21	32	Interest	Resident Days	1,527,029	77	377,597	0	14,207	3,513	21
22	33	Real Estate Taxes	Resident Days	1,527,029	77	40,405	0	14,207	376	22
23	34	Rent-Facility and Grounds	Resident Days	1,527,029	77	0	0	14,207	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,527,029	77	39,061	0	14,207	363	24
25	TOTALS					\$ 11,193,551	\$ 7,982,443		\$ 160,572	25

Facility Name & ID Number Shelbyville Rehabilitation & Health Care Center # 0047563 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 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

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	389,552	21	\$	\$ 14,207	\$	1
2	2	Food	Resident Days	389,552	21		14,207		2
3	3	Housekeeping	Resident Days	389,552	21		14,207		3
4	4	Laundry	Resident Days	389,552	21		14,207		4
5	5	Utilities	Resident Days	389,552	21		14,207		5
6	6	Maintenance	Resident Days	389,552	21		14,207		6
7	7	Mgmt. Allocation of Benefits	Resident Days	389,552	21		14,207		7
8	10	Nursing and Medical Records	Resident Days	389,552	21		14,207		8
9	12	Social Services	Resident Days	389,552	21		14,207		9
10	17	Administrative	Resident Days	389,552	21		14,207		10
11	19	Professional Services	Resident Days	389,552	21	17,164	14,207	626	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	389,552	21	16,534	14,207	603	12
13	21	Clerical and General Office	Resident Days	389,552	21	32,356	14,207	1,180	13
14	22	Employee Benefits & Payroll	Resident Days	389,552	21	62,830	14,207	2,291	14
15	23	Inservice Training & Education	Resident Days	389,552	21		14,207		15
16	24	Travel and Seminar	Resident Days	389,552	21		14,207		16
17	25	Other Admin. Staff Transport.	Resident Days	389,552	21		14,207		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	389,552	21		14,207		18
19	27	Mgmt. Allocation of Benefits	Resident Days	389,552	21		14,207		19
20	30	Depreciation	Resident Days	389,552	21	19,207	14,207	701	20
21	32	Interest	Resident Days	389,552	21	425,239	14,207	15,509	21
22	33	Real Estate Taxes	Resident Days	389,552	21		14,207		22
23	34	Rent-Facility and Grounds	Resident Days	389,552	21		14,207		23
24	35	Rent-Equipment & Vehicles	Resident Days	389,552	21		14,207		24
25	TOTALS					\$ 573,330	\$	\$ 20,910	25

**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	Bank of America		X	Mortgage	Varies	1/19/07	\$ 400,000	\$ 382,644	12/31/13	Varies	\$ 19,435	1							
2												2							
3							Interest Income Offset				(653)	3							
4							Home Office Allocation-PHC				3,513	4							
5							Home Office Allocation-PHO				15,509	5							
<b>Working Capital</b>																			
6												6							
7												7							
8												8							
9	<b>TOTAL Facility Related</b>						\$ 400,000	\$ 382,644			\$ 37,804	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>						\$ 400,000	\$ 382,644			\$ 37,804	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**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>			
1. Real Estate Tax accrual used on 2009 report.			\$	<b>30,000</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>29,313</b>	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(687)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	<b>30,240</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>376</b>	
<b>TOTAL REFUND</b>	\$	<b>For</b>	<b>Tax Year.</b>	<b>(Attach a copy of the real estate tax appeal board's decision.)</b>	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	<b>29,929</b>	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2005	<u>31,442</u>		8	
	2006	<u>26,896</u>		9	
	2007	<u>27,675</u>		10	
	2008	<u>29,125</u>		11	
	2009	<u>29,313</u>		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.**

**2009 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Shelbyville Rehabilitation & Health Care Center COUNTY Shelby

FACILITY IDPH LICENSE NUMBER 0047563

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)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>1812-13-01-103-005</u>	<u>Long-Term Care Facility</u>	\$ <u>29,312.84</u>	\$ <u>29,312.84</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>29,312.84</u></u>	\$ <u><u>29,312.84</u></u>

**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 Shelbyville Rehabilitation & Health Care Center

# 0047563

Report Period Beginning:

1/1/2010

Ending:

12/31/2010

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 16,099 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

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

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

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

N/A

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

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

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

**XI. OWNERSHIP COSTS:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>80,150</u>	<u>2005</u>	<u>\$ 47,250</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>80,150</b>		<b>\$ 47,250</b>	<b>3</b>



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	80	2005	1971	\$ 855,750	\$	25	\$ 34,230	\$ 34,230	\$ 188,265	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Original Land Improvements		2005	15,000		15	1,000	1,000	5,500	9
10	Sidewalks		2006	6,365		15	424	424	1,908	10
11	Water Heater		2006	6,609		10	661	661	2,311	11
12	Building Repair (Wind Damage)		2007	4,308		15	287	287	1,005	12
13	Sprinkler Installation		2008	5,990		7	856	856	2,140	13
14	Sprinkler System Repair		2009	7,455		7	1,065	1,065	1,598	14
15	Dry Pipe Valve Repair		2010	3,869		7	276	276	276	15
16	Sprinkler Line Repair		2010	4,106		7	293	293	293	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				1,424			(1,424)		30
31	Building Booked				34,256			(34,256)		31
32	Building Improvement Booked				2,853			(2,853)		32
33										33
34	2010-Home Office Allocation-Building Improvements			6,829			164	164		34
35	2010-Home Office Allocation-Land Improvements			637			35	35		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	<b>TOTAL (lines 4 thru 69)</b>	\$	\$		\$	\$	\$	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 206,887	\$ 30,548	\$ 29,284	\$ (1,264)	5-10 yrs.	\$ 153,565	71
72	Current Year Purchases	2,840	165	142	(23)	10 yrs.	142	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			3,550	3,550			74
75	TOTALS	\$ 209,727	\$ 30,713	\$ 32,976	\$ 2,263		\$ 153,707	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)	\$ 1,173,895	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 69,246	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 72,267	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 3,021	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 357,003	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: \$ 16,300 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	Ford E250 Van	\$ 578.17	\$ 6,938	17
18					18
19					19
20					20
21	TOTAL		\$ 578.17	\$ 6,938	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_  
Ending \_\_\_\_\_

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2011</u>	\$ _____
13.	<u>/2012</u>	\$ _____
14.	<u>/2013</u>	\$ _____

\* 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.

**Shelbyville Rehabilitation & Health Care Center  
0047563**

**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	\$ 11,332
Dishwasher	708
Copier	3,897
Home Office Allocation	363
	<u>16,300</u>

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<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**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
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	\$	4,863	\$ 72,941	\$	4,863	\$ 72,941	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,584	23,756		1,584	23,756	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		5,667	85,006	(24)	5,667	84,982	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				40,451		40,451	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>			\$	12,114	\$ 181,703	\$ 40,427	12,114	\$ 222,130	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 Shelbyville Rehabilitation & Health Care Center

# 0047563

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*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 576,440	\$ 576,440	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>N/A</u> )	156,993	156,993	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	20,884	20,884	6
7	Other Prepaid Expenses	6,592	6,592	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>	\$ 760,909	\$ 760,909	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	68,615	47,250	13
14	Buildings, at Historical Cost	855,750	862,579	14
15	Leasehold Improvements, at Historical Cost	25,728	54,339	15
16	Equipment, at Historical Cost	216,336	209,727	16
17	Accumulated Depreciation (book methods)	(346,221)	(357,003)	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>	\$ 820,208	\$ 816,892	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,581,117	\$ 1,577,801	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 261,771	\$ 261,771	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	12,926	12,926	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,363	10,363	31
32	Accrued Real Estate Taxes(Sch.IX-B)	30,240	30,240	32
33	Accrued Interest Payable	1,718	1,718	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Payroll Withholdings</u>	14,267	14,267	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 331,285	\$ 331,285	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable	382,644	382,644	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<u>Intercompany Loan-Mason Point</u>	23,128	23,128	43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 405,772	\$ 405,772	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 737,057	\$ 737,057	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 844,060	\$ 840,744	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,581,117	\$ 1,577,801	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>735,280</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Rounding</b>	<b>3</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>735,283</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>108,777</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>108,777</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>844,060</b>	<b>24</b> *

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

Facility Name & ID Number Shelbyville Rehabilitation & Health Care Center # 0047563 Report 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	\$ 1,938,574	1
2	Discounts and Allowances for all Levels	(125,033)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 1,813,541	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	266,422	6
7	Oxygen	696	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 267,118	8
<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	2,518	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	73,814	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	21,189	20
21	Other Medical Services	4,547	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 102,068	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	653	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 653	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Miscellaneous Revenue	955	28
28a	Transportation Revenue	1,869	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 2,824	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,186,204	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	402,853	31
32	Health Care	923,260	32
33	General Administration	432,528	33
<b>B. Capital Expense</b>			
34	Ownership	142,204	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	132,782	35
36	Provider Participation Fee	43,800	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,077,427	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	108,777	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 108,777	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 Shelbyville Rehabilitation & Health Care Center

# 0047563

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	1,907	2,085	\$ 55,914	\$ 26.82	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,969	1,969	37,591	19.09	3
4	Licensed Practical Nurses	12,034	12,520	228,978	18.29	4
5	CNAs & Orderlies	25,319	26,057	259,747	9.97	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,193	1,193	13,969	11.71	9
10	Activity Assistants	1,084	1,135	9,307	8.20	10
11	Social Service Workers	1,921	2,108	30,662	14.55	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	28,069	13.49	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,623	9,889	84,302	8.52	15
16	Dishwashers					16
17	Maintenance Workers	2,080	2,080	26,735	12.85	17
18	Housekeepers	5,919	6,184	51,063	8.26	18
19	Laundry	1,721	1,895	15,544	8.20	19
20	Administrator	3,460	3,460	102,609	29.66	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,992	1,992	24,605	12.35	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 Pg. 20 A</u>	3,108	3,108	55,184	17.76	33
34	TOTAL (lines 1 - 33)	75,410	77,755	\$ 1,024,279 *	\$ 13.17	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$		35
36	Medical Director	Monthly 13,500	9(3)	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 2,345	10(3)	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 15,845		49

**C. CONTRACT NURSES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	33 \$ 1,363	10(3)	50
51	Licensed Practical Nurses	7 259	10(3)	51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)	40 \$ 1,622		53

**Shelbyville Rehabilitation & Health 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>	2,109	2,109	43,154	20.46
<b>Transportation</b>	192	192	2,151	11.20
<b>Marketing</b>	807	807	9,879	12.24
<b>TOTAL</b>	<b>3,108</b>	<b>3,108</b>	<b>55,184</b>	

**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	
Daniel McQuality	Administrator	0	\$ 24,634	Workers' Compensation Insurance	\$ 35,486	IDPH License Fee	\$ 995	
Shannon Moore	Administrator	0	28,325	Unemployment Compensation Insurance	18,565	Advertising: Employee Recruitment	3,157	
Shannon Paden	Administrator	0	49,650	FICA Taxes	68,346	Health Care Worker Background Check		
				Employee Health Insurance	(10,019)	(Indicate # of checks performed)		
				Employee Meals		<u>Patient Background Checks</u>	<u>108</u>	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	633	
				<u>Employee Relations</u>	<u>1,183</u>	Miscellaneous Dues & Subscriptions	690	
				<u>Employee Retirement</u>	<u>373</u>	IHCA Dues	1,100	
				<u>Life Insurance</u>	<u>(346)</u>	Home Office Allocation	1,329	
				<u>Home Office Allocation</u>	<u>2,291</u>			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 102,609			Less: Public Relations Expense	(690)	
						Non-allowable advertising	( )	
						Yellow page advertising	( )	
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 115,879	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 8,294	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
<u>Management Fees-See Page 6, Eliminated on P 3, C 7</u>			\$ 229,000				Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 229,000				Seminar Expense	
							<u>Home Office Allocation</u>	22
							Entertainment Expense	( )
							TOTAL	\$ 22
							(agree to Sch. V, line 24, col. 8)	
				TOTAL		\$		

\* Attach copy of IMRF notifications

\*\*See instructions.

**Shelbyville Rehabilitation & Health Care Center**

**0047563**

**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)		3,748

**Home Office Allocation**

Heyl, Royster, Voelker & Allen	Legal	3
Healthcare Resources International	Legal	36
Ginoli & Company	Accountants	1,144
Bank of America	Accountants	114
Miscellaneous Vendors	Computer Services	17
VisionShare	Computer Services	156
Advanced Answers on Demand	Computer Services	980
Access 2 Go	Computer Services	159
Kemper Technology	Computer Services	135
MediFax	Computer Services	56
LogmeIn	Computer Services	40
Simple LTC	Computer Services	625
Optimizer Systems	Other Professional I	23
Clifton Gunderson	Other Professional I	70
Total (agree to Schedule V, line 19, column 8)		<u>7,306</u>



Facility Name & ID Number Shelbyville Rehabilitation & Health Care Center# 0047563Report 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. 1,100 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. \$ 5,858 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. \$ 43,800  
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. \$ 2,518
- (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. \$ 1,869  
c. What percent of all travel expense relates to transportation of nurses and patients? 100  
d. Have vehicle usage logs been maintained? Adequate records have been maintained.  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
**g. Does the facility transport residents to and from day training? N/A**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Ginoli & Company
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.