FOR BHF USE

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

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

I. IDPH License ID Number: 0050344

Facility Name: Westside Rehabilitation & Care Center

Address: 601 North Columbia (Number) West Frankfort (City) 62896 (Zip Code)

County: Franklin

Telephone Number: (618) 932-2109 **Fax #** (618)\937-3289

HFS ID Number:

Date of Initial License for Current Owners: 3/1/2009

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 Westside Rehabilitation & Care Center # 0050344 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	96	Skilled (SNF)	96	35,040	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	96	TOTALS	96	35,040	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	10,449	4,984	1,484	16,917	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,449	4,984	1,484	16,917	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 48.28%

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 3/1/2009

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 3/1/2009 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 40 and days of care provided 1,408

Medicare Intermediary Wisconsin Physicians Service

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 Westside Rehabilitation & Care Center # 0050344 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	105,313	6,851	858	113,022		113,022	3,151	116,173			1
2	Food Purchase		88,797		88,797		88,797	(948)	87,849			2
3	Housekeeping	75,310	12,422		87,732		87,732	37	87,769			3
4	Laundry	60,880	10,437		71,317		71,317		71,317			4
5	Heat and Other Utilities			53,480	53,480		53,480	313	53,793			5
6	Maintenance	34,795	11,603	12,396	58,794		58,794	1,834	60,628			6
7	Other (specify):* Home Off. Ben. All.							738	738			7
8	TOTAL General Services	276,298	130,110	66,734	473,142		473,142	5,125	478,267			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	685,577	47,402	1,585	734,564		734,564	(1,002)	733,562			10
10a	Therapy		477	173,145	173,622		173,622		173,622			10a
11	Activities	27,396	1,595	1,896	30,887		30,887		30,887			11
12	Social Services	30,839			30,839		30,839		30,839			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Off. Ben. All.											15
16	TOTAL Health Care and Programs	743,812	49,474	188,626	981,912		981,912	(1,002)	980,910			16
	C. General Administration											
17	Administrative			114,000	114,000		114,000	(57,266)	56,734			17
18	Directors Fees											18
19	Professional Services			12,800	12,800		12,800	3,491	16,291			19
20	Dues, Fees, Subscriptions & Promotions			5,878	5,878		5,878	740	6,618			20
21	Clerical & General Office Expenses	39,097	8,177	22,144	69,418		69,418	31,227	100,645			21
22	Employee Benefits & Payroll Taxes			188,553	188,553		188,553		188,553			22
23	Inservice Training & Education							225	225			23
24	Travel and Seminar			45	45		45	26	71			24
25	Other Admin. Staff Transportation			2,327	2,327		2,327	2,822	5,149			25
26	Insurance-Prop.Liab.Malpractice			37,487	37,487		37,487	468	37,955			26
27	Other (specify):* Home Off. Ben. All.							12,798	12,798			27
28	TOTAL General Administration	39,097	8,177	383,234	430,508		430,508	(5,469)	425,039			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,059,207	187,761	638,594	1,885,562		1,885,562	(1,346)	1,884,216			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 Westside Rehabilitation & Care Center #0050344 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			1,702	1,702		1,702	84,429	86,131			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							61,842	61,842			32
33	Real Estate Taxes							27,071	27,071			33
34	Rent-Facility & Grounds			106,645	106,645		106,645	(106,645)				34
35	Rent-Equipment & Vehicles			20,482	20,482		20,482	433	20,915			35
36	Other (specify):*											36
37	**TOTAL Ownership**			128,829	128,829		128,829	67,130	195,959			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		50,808		50,808		50,808		50,808			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			52,560	52,560		52,560		52,560			42
43	Other (specify):* Non-allowable Cost		150	41,202	41,352		41,352	(41,352)				43
44	**TOTAL Special Cost Centers**		50,958	93,762	144,720		144,720	(41,352)	103,368			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,059,207	238,719	861,185	2,159,111		2,159,111	24,432	2,183,543			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 Westside Rehabilitation & Care Center # 0050344 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	(948)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,081)	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	(11,772)	30		9
10	Interest and Other Investment Income	(125)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(63)	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	(5,936)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(19,003)	43		24
25	Fund Raising, Advertising and Promotional	(1,429)	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	(13,751)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (56,108)		$	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)	80,540	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 80,540		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 24,432		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

Westside Rehabilitation & Care Center

ID# 0050344

Report Period Beginning: 1/1/2010

Ending: 12/31/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs-Part A	$ (5,825)	43	1
2	X-Rays-Part A	(3,180)	43	2
3	Disallowed Special Events	(40)	43	3
4	Offset Miscellaneous Office Supplies Revenue	(136)	21	4
5	Pet Expense	(2,795)	43	5
6	Offset Nursing Supplies Revenue	(1,050)	10	6
7	Disallowed Dues	(125)	20	7
8	Disallowed Real Estate Tax Late Fees	(600)	33	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(13,751)		49

Facility Name & ID Number Westside Rehabilitation & Care Center # 0050344 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%	$ 3,151	$ 3,151	1
2	V	2	Food		Petersen Health Care, Inc.	100.00%	0		2
3	V	3	Housekeeping		Petersen Health Care, Inc.	100.00%	37	37	3
4	V	4	Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5	Utilities		Petersen Health Care, Inc.	100.00%	313	313	5
6	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	1,834	1,834	6
7	V	7	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	738	738	7
8	V	10	Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	48	48	8
9	V	11	Activities		Petersen Health Care, Inc.	100.00%	0		9
10	V	15	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		10
11	V	17	Administrative	114,000	Petersen Health Care, Inc.	100.00%	56,734	(57,266)	11
12	V	19	Professional Services		Petersen Health Care, Inc.	100.00%	3,491	3,491	12
13	V								13
14	Total			$ 114,000			$ 66,346	$ * (47,654)	14

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

Facility Name & ID Number Westside Rehabilitation & Care Center # 0050344 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	20	Dues, Fees, Subs and Promotions	$	Petersen Health Care, Inc.	100.00%	$ 865	$ 865	15
16	V	21	Clerical and General Office		Petersen Health Care, Inc.	100.00%	31,363	31,363	16
17	V	23	Inservice Training and Education		Petersen Health Care, Inc.	100.00%	225	225	17
18	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	26	26	18
19	V	25	Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	2,822	2,822	19
20	V	26	Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	468	468	20
21	V	27	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	12,798	12,798	21
22	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	3,630	3,630	22
23	V	32	Interest		Petersen Health Care, Inc.	100.00%	4,183	4,183	23
24	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	448	448	24
25	V	34	Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0		25
26	V	35	Rent-Equipment and Vehicles		Petersen Health Care, Inc.	100.00%	433	433	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			$			$ 57,261	$ * 57,261	39

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

Facility Name & ID Number Westside Rehabilitation & Care Center # 0050344 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	30	Depreciation	$	Petersen West Frankfort, LLC	100.00%	$ 92,571	$ 92,571	15
16	V	32	Amortization		Petersen West Frankfort, LLC	100.00%	21,742	21,742	16
17	V	32	Interest		Petersen West Frankfort, LLC	100.00%	36,042	36,042	17
18	V	33	Real Estate Taxes		Petersen West Frankfort, LLC	100.00%	27,223	27,223	18
19	V	34	Rent-Facility and Grounds	106,645	Petersen West Frankfort, LLC	100.00%		(106,645)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								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			$ 106,645			$ 177,578	$ * 70,933	39

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

Facility Name & ID Number Westside Rehabilitation & Care Center # 0050344 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	180,101	0.64	1.07	Salary	$ 2,149	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	$ 2,149		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 Westside Rehabilitation & Care Center # 0050344 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	16,917	$ 3,151	1
2	2	Food	Resident Days	1,527,029	77	0	0	16,917	0	2
3	3	Housekeeping	Resident Days	1,527,029	77	3,369	0	16,917	37	3
4	4	Laundry	Resident Days	1,527,029	77	0	0	16,917	0	4
5	5	Utilities	Resident Days	1,527,029	77	28,267	0	16,917	313	5
6	6	Maintenance	Resident Days	1,527,029	77	165,545	121,901	16,917	1,834	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,527,029	77	66,650	0	16,917	738	7
8	10	Nursing and Medical Records	Resident Days	1,527,029	77	4,339	0	16,917	48	8
9	10A	Therapy	Resident Days	1,527,029	77	0	0	16,917	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,527,029	77	0	0	16,917	0	10
11	17	Administrative	Resident Days	1,527,029	77	5,157,152	5,157,152	16,917	56,734	11
12	19	Professional Services	Resident Days	1,527,029	77	315,156	0	16,917	3,491	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,527,029	77	78,050	0	16,917	865	13
14	21	Clerical and General Office	Resident Days	1,527,029	77	2,830,968	2,420,380	16,917	31,363	14
15	23	Inservice Training & Education	Resident Days	1,527,029	77	20,336	0	16,917	225	15
16	24	Travel and Seminar	Resident Days	1,527,029	77	2,344	0	16,917	26	16
17	25	Other Admin. Staff Transport.	Resident Days	1,527,029	77	254,752	0	16,917	2,822	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,527,029	77	42,233	0	16,917	468	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,527,029	77	1,155,252	0	16,917	12,798	19
20	30	Depreciation	Resident Days	1,527,029	77	327,648	0	16,917	3,630	20
21	32	Interest	Resident Days	1,527,029	77	377,597	0	16,917	4,183	21
22	33	Real Estate Taxes	Resident Days	1,527,029	77	40,405	0	16,917	448	22
23	34	Rent-Facility and Grounds	Resident Days	1,527,029	77	0	0	16,917	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,527,029	77	39,061	0	16,917	433	24
25	TOTALS					$ 11,193,551	$ 7,982,443		$ 123,607	25

Facility Name & ID Number Westside Rehabilitation & Care Center # 0050344 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	3/1/09	$ 1,312,500	$ 1,235,937	12/31/13	Varies	$ 36,042	1
2												2
3							Interest Income Offset				(125)	3
4							Home Office Allocation-PHC				4,183	4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 1,312,500	$ 1,235,937			$ 40,100	9
	B. Non-Facility Related*											
10							Amortization Expense				21,742	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 21,742	14
15	TOTALS (line 9+line14)						$ 1,312,500	$ 1,235,937			$ 61,842	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 Westside Rehabilitation & Care Center **#** 0050344 **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.**	$ 27,600	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	$ 26,683	2
3. Under or (over) accrual (line 2 minus line 1).		$ (917)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 27,540	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**		448	
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.		$ 27,071	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005	25,547	8
2006	28,662	9
2007	26,734	10
2008	26,770	11
2009	26,683	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 Westside Rehabilitation & Care Center COUNTY Franklin

FACILITY IDPH LICENSE NUMBER 0050344

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.	11-24-105-002	601 N. Columbia, West Frankfort, IL	$ 26,682.68	$ 26,682.68
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 26,682.68	$ 26,682.68

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 Westside Rehabilitation & Care Center # 0050344 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 23,727 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 1

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

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

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

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

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

N/A

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

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

3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	17,241	2009	$ 180,000	1
2					2
3	TOTALS	17,241		$ 180,000	3

Facility Name & ID Number Westside Rehabilitation & Care Center # 0050344 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	96		2009	1979	$ 1,350,000	$	25	$ 54,000	$ 54,000	$ 81,000	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Roof Repair			2010	2,750		7	196	196	196	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31	Building Booked					54,000			(54,000)		31
32	Building Improvement Booked					393			(393)		32
33											33
34	2010-Home Office Allocation-Building Improvements				8,131			42	42		34
35	2010-Home Office Allocation-Land Improvements				759			195	195		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 Westside Rehabilitation & Care Center # 0050344 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,361,640	$ 54,393		$ 54,433	$ 40	$ 81,196	70

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

Facility Name & ID Number Westside Rehabilitation & Care Center # 0050344 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	$ 275,367	$ 39,338	$ 27,537	$ (11,801)	10 yrs.	$ 41,305	71
72	Current Year Purchases	10,629	543	531	(12)	10 yrs.	531	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			3,630	3,630			74
75	TOTALS	$ 285,996	$ 39,881	$ 31,698	$ (8,183)		$ 41,836	75

D. Vehicle Depreciation (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,827,636	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 94,274	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 86,131	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (8,143)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 123,032	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 Westside Rehabilitation & Care Center # 0050344 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

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

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

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

16. Rental Amount for movable equipment: $ 20,915 Description: See Attached Schedule 14A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Westside Rehabilitation & Care Center
0050344
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	$	15,546
Dishwasher		708
Copier		4,228
Home Office Allocation		433
		20,915

Facility Name & ID Number Westside Rehabilitation & Care Center # 0050344 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 Westside Rehabilitation & Care Center # 0050344 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		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	$	3,921	$ 58,815	$	3,921	$ 58,815	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2,867	43,012		2,867	43,012	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		4,755	71,318	477	4,755	71,795	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				50,808		50,808	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			$	11,543	$ 173,145	$ 51,285	11,543	$ 224,430	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 Westside Rehabilitation & Care Center # 0050344 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	$ 131,488	$ 131,488	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance N/A)	124,879	128,612	3
4	Supply Inventory (priced at Cost)	6,808	6,808	4
5	Short-Term Investments			5
6	Prepaid Insurance	25,060	25,060	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Security Deposit	50	50	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 288,285	$ 292,018	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		180,000	13
14	Buildings, at Historical Cost		1,358,131	14
15	Leasehold Improvements, at Historical Cost	2,750	3,509	15
16	Equipment, at Historical Cost	15,996	285,996	16
17	Accumulated Depreciation (book methods)	(1,845)	(123,032)	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 (spe Loan Costs		65,224	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 16,901	$ 1,769,828	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 305,186	$ 2,061,846	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 253,149	$ 253,149	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	65,834	65,834	30
31	Accrued Taxes Payable (excluding real estate taxes)	41,427	41,427	31
32	Accrued Real Estate Taxes(Sch.IX-B)		27,540	32
33	Accrued Interest Payable		3,733	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	30,420	30,420	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 390,830	$ 422,103	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,235,937	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Due To Related Parties	(140,054)	(400,000)	43
44	A/P-Prior Owner	31,658	31,658	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ (108,396)	$ 867,595	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 282,434	$ 1,289,698	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 22,752	$ 772,148	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 305,186	$ 2,061,846	48

*(See instructions.)

Facility Name & ID Number Westside Rehabilitation & Care Center # 0050344 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**	$ 166,937	1
2	Restatements (describe):		2
3	**Rounding**	(2)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 166,935	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(219,183)	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	75,000	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)**	$ (144,183)	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)**	$ 22,752	24 *

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

Facility Name & ID Number Westside Rehabilitation & Care Center # 0050344 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	$ 1,669,721	1
2	Discounts and Allowances for all Levels	(57,237)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,612,484	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	234,496	6
7	Oxygen	583	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 235,079	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	948	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	76,737	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	11,267	20
21	Other Medical Services	2,102	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 91,054	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	125	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 125	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	1,186	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,186	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,939,928	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	473,142	31
32	Health Care	981,912	32
33	General Administration	430,508	33
	B. Capital Expense		
34	Ownership	128,829	34
	C. Ancillary Expense		
35	Special Cost Centers	92,160	35
36	Provider Participation Fee	52,560	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,159,111	40
41	**Income before Income Taxes (line 30 minus line 40)****	(219,183)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (219,183)	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 Westside Rehabilitation & Care Center # 0050344 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	2,048	2,064	$ 52,748	$ 25.56	1
2	Assistant Director of Nursing	2,080	2,080	36,661	17.63	2
3	Registered Nurses	4,266	4,471	83,171	18.60	3
4	Licensed Practical Nurses	11,152	11,463	186,906	16.31	4
5	CNAs & Orderlies	34,201	35,243	326,091	9.25	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	428	500	5,747	11.49	9
10	Activity Assistants	2,210	2,232	19,589	8.78	10
11	Social Service Workers	2,080	2,080	30,839	14.83	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	26,053	12.53	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,240	9,484	79,260	8.36	15
16	Dishwashers					16
17	Maintenance Workers	2,080	2,080	34,795	16.73	17
18	Housekeepers	8,805	9,095	75,310	8.28	18
19	Laundry	6,435	6,842	60,880	8.90	19
20	Administrator	2,032	2,032	54,585	26.86	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,339	3,565	39,097	10.97	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) Transportation	179	224	2,060	9.20	33
34	TOTAL (lines 1 - 33)	92,655	95,535	$ 1,113,792 *	$ 11.66	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	Monthly	$ 858	1(3)	35
36	Medical Director	Monthly	12,000	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	931	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)		$ 13,789		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	N/A			51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Westside Rehabilitation & Care Center # 0050344 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
James Barron	Administrator	0	$ 28,385
Marsha McKinney	Administrator	0	26,200
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 54,585

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 114,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 114,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
E-Health Data Solutions	Computer Services	$ 3,420
Ginoli and Company	Accounting Services	805
Brown & James P.C.	Legal Services	2,347
Clifton Gunderson	Accounting Services	5,000
Mediacom	Computer Services	1,228
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 12,800

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 37,721
Unemployment Compensation Insurance	62,136
FICA Taxes	79,839
Employee Health Insurance	7,584
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	900
Life Insurance	373
TOTAL (agree to Schedule V, line 22, col.8)	$ 188,553

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	$ 1,298
Advertising: Employee Recruitment	1,632
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks 101	1,010
Miscellaneous Licenses & Permits	513
Miscellaneous Dues & Subscriptions	125
IHCA Dues	1,300
Home Office Allocation	865
Less: Public Relations Expense	(125)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,618

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	45
Home Office Allocation	26
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 71

**See instructions.

Westside Rehabilitation & Care Center
0050344
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)		12,800
Home Office Allocation		
Heyl, Royster, Voelker & Allen	Legal	3
Healthcare Resources International	Legal	43
Ginoli & Company	Accountants	617
Bank of America	Accountants	136
Miscellaneous Vendors	Computer Services	20
VisionShare	Computer Services	186
Advanced Answers on Demand	Computer Services	1,167
Access 2 Go	Computer Services	190
Kemper Technology	Computer Services	161
MediFax	Computer Services	67
Logmeln	Computer Services	47
Simple LTC	Computer Services	744
Optimizer Systems	Other Professional Fees	27
Clifton Gunderson	Other Professional Fees	83
Total (agree to Schedule V, line 19, column 8)		16,291

Facility Name & ID Number Westside Rehabilitation & Care Center # 0050344 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 Westside Rehabilitation & Care Center # 0050344 **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. **1,300 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. $ **3,547** 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. $ **52,560**
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. $ **948**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **Yes** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **0**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? **N/A**
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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

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