

Facility Name & ID Number Bloomington Rehabilitation & Health Care Center

0047415 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	26	Skilled (SNF)	26	9,490	1
2		Skilled Pediatric (SNF/PED)			2
3	52	Intermediate (ICF)	52	18,980	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	78	TOTALS	78	28,470	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			1,373	1,373	8
9	SNF/PED					9
10	ICF	13,046	554		13,600	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,046	554	1,373	14,973	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 52.59%

D. How many bed-hold days during this year were paid by the Department?

0 (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 10/01/05

J. Was the facility purchased or leased after January 1, 1978?

YES Date 10/01/05 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number

of beds certified 26 and days of care provided 1,373

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bloomington Rehabilitation & Health Care C # 0047415 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	106,954	7,950	4,174	119,078		119,078	1,488	120,566		1
2	Food Purchase		70,817		70,817		70,817	(5,233)	65,584		2
3	Housekeeping	60,902	5,610		66,512		66,512	48	66,560		3
4	Laundry	7,322	7,557		14,879		14,879		14,879		4
5	Heat and Other Utilities			49,194	49,194		49,194	197	49,391		5
6	Maintenance	49,441	24,234	15,711	89,386		89,386	3,689	93,075		6
7	Other (specify):* Home Office Benefits							927	927		7
8	TOTAL General Services	224,619	116,168	69,079	409,866		409,866	1,116	410,982		8
	B. Health Care and Programs										
9	Medical Director			7,950	7,950		7,950		7,950		9
10	Nursing and Medical Records	662,328	94,516	4,381	761,225		761,225	4,554	765,779		10
10a	Therapy		71	157,243	157,314		157,314	353	157,667		10a
11	Activities	33,210	1,168	1,061	35,439		35,439		35,439		11
12	Social Services	1,638	21		1,659		1,659		1,659		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Office Benefits							1,446	1,446		15
16	TOTAL Health Care and Programs	697,176	95,776	170,635	963,587		963,587	6,353	969,940		16
	C. General Administration										
17	Administrative	61,087		36,500	97,587		97,587	(25,118)	72,469		17
18	Directors Fees										18
19	Professional Services			3,450	3,450		3,450	6,521	9,971		19
20	Dues, Fees, Subscriptions & Promotions			8,226	8,226		8,226	733	8,959		20
21	Clerical & General Office Expenses	33,678	5,580	10,075	49,333		49,333	20,685	70,018		21
22	Employee Benefits & Payroll Taxes			156,058	156,058		156,058	3,860	159,918		22
23	Inservice Training & Education			464	464		464	137	601		23
24	Travel and Seminar			405	405		405	550	955		24
25	Other Admin. Staff Transportation			3,436	3,436		3,436	1,615	5,051		25
26	Insurance-Prop.Liab.Malpractice			12,923	12,923		12,923	844	13,767		26
27	Other (specify):* Home Office Benefits							4,120	4,120		27
28	TOTAL General Administration	94,765	5,580	231,537	331,882		331,882	13,947	345,829		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,016,560	217,524	471,251	1,705,335		1,705,335	21,416	1,726,751		29

SEE ACCOUNTANTS' COMPILATION REPORT

*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.

**See schedule of adjustments attached at end of cost report.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			39,268	39,268		39,268	5,149	44,417			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			70,524	70,524		70,524	12,263	82,787			32
33	Real Estate Taxes			25,000	25,000		25,000	1,479	26,479			33
34	Rent-Facility & Grounds							674	674			34
35	Rent-Equipment & Vehicles			33,974	33,974		33,974	440	34,414			35
36	Other (specify):*											36
37	TOTAL Ownership			168,766	168,766		168,766	20,005	188,771			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			5,500	5,500		5,500		5,500			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			42,705	42,705		42,705		42,705			42
43	Other (specify):* Nonallowable Cost			78,703	78,703		78,703	(78,703)				43
44	TOTAL Special Cost Centers			126,908	126,908		126,908	(78,703)	48,205			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,016,560	217,524	766,925	2,001,009		2,001,009	(37,282)	1,963,727			45

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

**See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(4,855)	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	162	30		9
10	Interest and Other Investment Income	(3,115)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(154)	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	(13,218)	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	(49,628)	43		24
25	Fund Raising, Advertising and Promotional	(3,145)	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 Schedule 5A	(13,646)	Var		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (87,599)		\$	30

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

		1	2	
		Amount	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)	50,317	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 50,317		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (37,282)		37

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

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

		1	2	3	4
		Yes	No	Amount	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	Exceptional Care Program		x		44
45	Other-Attach Schedule		x		45
46	Other-Attach Schedule		x		46
47	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY					
48		49		50	
				51	
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Bloomington Rehabilitation & Health Care Center

ID# 0047415

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Nonallowable marketing events	\$ (527)	43	1
2	Labs - Part A	(2,852)	43	2
3	Misc - Part A Procedures	(1,169)	43	3
4	Special Events	(3,155)	43	4
5	Offset Meal Revenue	(1,428)	2	5
6	Offset Miscellaneous Revenue	(201)	21	6
7	Nonallowable Home Office Architect Fees	(332)	21	7
8	Offset Nursing Supplies	(41)	10	8
9	Offset nonallowable Home Office travel	(3,941)	24	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	(13,646)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Bloomington Rehabilitation & Health Care Center# 0047415

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	1,065	0	423	0	0	0	0	0	0	0	1,488	1
2	Food Purchase	(1,428)	52	0	3	0	0	0	0	0	0	0	(1,373)	2
3	Housekeeping	0	47	0	1	0	0	0	0	0	0	0	48	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	197	0	0	0	0	0	0	0	0	0	197	5
6	Maintenance	0	2,708	0	981	0	0	0	0	0	0	0	3,689	6
7	Other (specify):*	0	427	0	500	0	0	0	0	0	0	0	927	7
8	TOTAL General Services	(1,428)	4,496	0	1,908	0	4,976	8						
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(41)	3,849	0	746	0	0	0	0	0	0	0	4,554	10
10a	Therapy	0	353	0	0	0	0	0	0	0	0	0	353	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	1,190	0	256	0	0	0	0	0	0	0	1,446	15
16	TOTAL Health Care and Programs	(41)	5,392	0	1,002	0	6,353	16						
	C. General Administration													
17	Administrative	0	(26,007)	0	889	0	0	0	0	0	0	0	(25,118)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	4,596	0	1,925	0	0	0	0	0	0	0	6,521	19
20	Fees, Subscriptions & Promotions	0	450	0	283	0	0	0	0	0	0	0	733	20
21	Clerical & General Office Expenses	(533)	0	16,915	4,303	0	0	0	0	0	0	0	20,685	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	137	0	0	0	0	0	0	0	0	137	23
24	Travel and Seminar	(3,941)	0	4,096	395	0	0	0	0	0	0	0	550	24
25	Other Admin. Staff Transportation	0	0	1,090	525	0	0	0	0	0	0	0	1,615	25
26	Insurance-Prop.Liab.Malpractice	0	0	806	38	0	0	0	0	0	0	0	844	26
27	Other (specify):*	0	0	2,990	1,130	0	0	0	0	0	0	0	4,120	27
28	TOTAL General Administration	(4,474)	(20,961)	26,034	9,488	0	10,087	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(5,943)	(11,073)	26,034	12,398	0	21,416	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Bloomington Rehabilitation & Health Care Center # 0047415 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	162	0	4,171	816	0	0	0	0	0	0	0	5,149	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,115)	0	2,317	13,061	0	0	0	0	0	0	0	12,263	32
33	Real Estate Taxes	0	0	489	990	0	0	0	0	0	0	0	1,479	33
34	Rent-Facility & Grounds	0	0	474	200	0	0	0	0	0	0	0	674	34
35	Rent-Equipment & Vehicles	0	0	248	192	0	0	0	0	0	0	0	440	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(2,953)	0	7,699	15,259	0	20,005	37						
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(78,703)	0	0	0	0	0	0	0	0	0	0	(78,703)	43
44	TOTAL Special Cost Centers	(78,703)	0	0	0	0	0	0	0	0	0	0	(78,703)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(87,599)	(11,073)	33,733	27,657	0	(37,282)	45						

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 Petersen		See Attached Schedule 6A		See Attached Schedule 6A		

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 1,065	\$ 1,065	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	52	52	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	47	47	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%			4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	197	197	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	2,708	2,708	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	427	427	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	3,849	3,849	8
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	353	353	9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,190	1,190	10
11	V	17 Administrative	36,500	Petersen Health Care, Inc.	100.00%	10,493	(26,007)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	4,596	4,596	12
13	V	20 Due, Fees, Subs & Promos		Petersen Health Care, Inc.	100.00%	450	450	13
14	Total		\$ 36,500			\$ 25,427	\$ * (11,073)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	21 Clerical & General Office	\$	Petersen Health Care, Inc.	100.00%	\$ 16,915	\$	16,915	15
16	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	137		137	16
17	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	4,096		4,096	17
18	V	25 Other Admin. Staff Transport		Petersen Health Care, Inc.	100.00%	1,090		1,090	18
19	V	26 Insurance-Prop.Liab.Malpractice		Petersen Health Care, Inc.	100.00%	806		806	19
20	V	27 Mgmt Allocation of Benefits		Petersen Health Care, Inc.	100.00%	2,990		2,990	20
21	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	4,171		4,171	21
22	V	32 Interest		Petersen Health Care, Inc.	100.00%	2,317		2,317	22
23	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	489		489	23
24	V	34 Rent - Facility & Grounds		Petersen Health Care, Inc.	100.00%	474		474	24
25	V	35 Rent - Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	248		248	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		\$			\$ 33,733	\$ *	33,733	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

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 Care, Inc.	100.00%	\$ 423	\$	423	15
16	V	2 Food		Petersen Health Care, Inc.	100.00%	3		3	16
17	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	1		1	17
18	V	5 Utilities		Petersen Health Care, Inc.	100.00%				18
19	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	981		981	19
20	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	500		500	20
21	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	746		746	21
22	V	10A Therapy		Petersen Health Care, Inc.	100.00%				22
23	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	256		256	23
24	V	17 Administrative		Petersen Health Care, Inc.	100.00%	889		889	24
25	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	1,925		1,925	25
26	V	20 Due, Fees, Subs & Promos		Petersen Health Care, Inc.	100.00%	283		283	26
27	V	21 Clerical & General Office		Petersen Health Care, Inc.	100.00%	4,303		4,303	27
28	V	24 Travel & Seminar		Petersen Health Care, Inc.	100.00%	395		395	28
29	V	25 Other Admin. Staff Transport		Petersen Health Care, Inc.	100.00%	525		525	29
30	V	26 Insurance-Prop.Liab.Malpractice		Petersen Health Care, Inc.	100.00%	38		38	30
31	V	27 Mgmt Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,130		1,130	31
32	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	816		816	32
33	V	32 Interest		Petersen Health Care, Inc.	100.00%	13,061		13,061	33
34	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	990		990	34
35	V	34 Rent - Facility & Grounds		Petersen Health Care, Inc.	100.00%	200		200	35
36	V	35 Rent - Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	192		192	36
37	V								37
38	V								38
39	Total		\$			\$ 27,657	\$ *	27,657	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bloomington Rehabilitation & Health Care (# 0047415 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	See Schedule 7A	0.66	1.31	Salary	\$ 10,493	L17,C7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 10,493		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bloomington Rehabilitation & Health Care Center # 0047415 Report Period Beginning: 01/01/2006 Ending: 2/31/2006

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Petersen Health Care, Inc.
 Street Address 830 West 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	Patient Days	1,141,463	56	\$ 81,179	\$ 80,967	14,973	\$ 1,065	1
2	2	Food	Patient Days	1,141,463	56	3,989	0	14,973	52	2
3	3	Housekeeping	Patient Days	1,141,463	56	3,589	0	14,973	47	3
4	4	Laundry	Patient Days	1,141,463	56	0	0	14,973	0	4
5	5	Utilities	Patient Days	1,141,463	56	15,054	0	14,973	197	5
6	6	Maintenance	Patient Days	1,141,463	56	206,416	110,513	14,973	2,708	6
7	7	Mgmt. Allocation of Benefits	Patient Days	1,141,463	56	32,526	0	14,973	427	7
8	10	Nursing and Medical Records	Patient Days	1,141,463	56	293,462	289,197	14,973	3,849	8
9	10A	Therapy	Patient Days	1,141,463	56	26,945	0	14,973	353	9
10	15	Mgmt. Allocation of Benefits	Patient Days	1,141,463	56	90,724	0	14,973	1,190	10
11	17	Administrative	Patient Days	1,141,463	56	800,000	800,000	14,973	10,493	11
12	19	Professional Services	Patient Days	1,141,463	56	350,361	4,303	14,973	4,596	12
13	20	Due, Fees, Subs & Promos	Patient Days	1,141,463	56	34,325	0	14,973	450	13
14	21	Clerical & General Office	Patient Days	1,141,463	56	1,289,623	954,322	14,973	16,915	14
15	23	Inservice Training & Education	Patient Days	1,141,463	56	10,426	0	14,973	137	15
16	24	Travel and Seminar	Patient Days	1,141,463	56	312,259	0	14,973	4,096	16
17	25	Other Admin. Staff Transport	Patient Days	1,141,463	56	83,062	0	14,973	1,090	17
18	26	Insurance-Prop.Liab.Malpractice	Patient Days	1,141,463	56	61,457	0	14,973	806	18
19	27	Mgmt Allocation of Benefits	Patient Days	1,141,463	56	227,912	0	14,973	2,990	19
20	30	Depreciation	Patient Days	1,141,463	56	317,964	0	14,973	4,171	20
21	32	Interest	Patient Days	1,141,463	56	176,614	0	14,973	2,317	21
22	33	Real Estate Taxes	Patient Days	1,141,463	56	37,282	0	14,973	489	22
23	34	Rent - Facility & Grounds	Patient Days	1,141,463	56	36,133	0	14,973	474	23
24	35	Rent - Equipment & Vehicles	Patient Days	1,141,463	56	18,933	0	14,973	248	24
25	TOTALS					\$ 4,510,235	\$ 2,239,302		\$ 59,160	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bloomington Rehabilitation & Health Care Center # 0047415 Report Period Beginning: 01/01/2006 Ending: 2/31/2006

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 West 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	Patient Days	427,669	46	\$ 12,081	\$ 11,958	14,973	\$ 423	1
2	2	Food	Patient Days	427,669	46	93		14,973	3	2
3	3	Housekeeping	Patient Days	427,669	46	28		14,973	1	3
4	4	Laundry	Patient Days	427,669	46			14,973		4
5	5	Utilities	Patient Days	427,669	46			14,973		5
6	6	Maintenance	Patient Days	427,669	46	28,012	28,012	14,973	981	6
7	7	Mgmt. Allocation of Benefits	Patient Days	427,669	46	14,282		14,973	500	7
8	10	Nursing and Medical Records	Patient Days	427,669	46	21,299	20,434	14,973	746	8
9	10A	Therapy	Patient Days	427,669	46			14,973		9
10	15	Mgmt. Allocation of Benefits	Patient Days	427,669	46	7,301		14,973	256	10
11	17	Administrative	Patient Days	427,669	46	25,391	25,391	14,973	889	11
12	19	Professional Services	Patient Days	427,669	46	54,971		14,973	1,925	12
13	20	Due, Fees, Subs & Promos	Patient Days	427,669	46	8,088		14,973	283	13
14	21	Clerical & General Office	Patient Days	427,669	46	122,893	64,907	14,973	4,303	14
15	23	Inservice Training & Education	Patient Days	427,669	46			14,973		15
16	24	Travel and Seminar	Patient Days	427,669	46	11,280		14,973	395	16
17	25	Other Admin. Staff Transport	Patient Days	427,669	46	15,003		14,973	525	17
18	26	Insurance-Prop.Liab.Malpractice	Patient Days	427,669	46	1,087		14,973	38	18
19	27	Mgmt Allocation of Benefits	Patient Days	427,669	46	32,265		14,973	1,130	19
20	30	Depreciation	Patient Days	427,669	46	23,301		14,973	816	20
21	32	Interest	Patient Days	427,669	46	373,049		14,973	13,061	21
22	33	Real Estate Taxes	Patient Days	427,669	46	28,282		14,973	990	22
23	34	Rent - Facility & Grounds	Patient Days	427,669	46	5,700		14,973	200	23
24	35	Rent - Equipment & Vehicles	Patient Days	427,669	46	5,479		14,973	192	24
25	TOTALS					\$ 789,885	\$ 150,702		\$ 27,657	25

SEE ACCOUNTANTS' COMPILATION REPORT

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	Name of Lender	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			
A. Directly Facility Related																		
Long-Term																		
1	LaSalle Bank		X	Mortgage	Varies	09/30/05	\$ 610,000	\$ 601,096	09/20/10	Varies	\$ 51,865	1						
2	Ziegler Healthcare		X	Mortgage	Varies	09/30/05	120,000	119,780	09/20/10	0.1000	18,659	2						
3												3						
4							Interest Income Offset				(3,115)	4						
5							Allocated from Home Office				15,378	5						
Working Capital																		
6												6						
7												7						
8												8						
9	TOTAL Facility Related						\$ 730,000	\$ 720,876			\$ 82,787	9						
B. Non-Facility Related*																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 730,000	\$ 720,876			\$ 82,787	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.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2005 report.		\$	24,814	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.)	2005	\$	24,814	2
3. Under or (over) accrual (line 2 minus line 1).		\$		3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	25,000	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			1,479	
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.		\$	26,479	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2001	_____	8	
	2002	_____	9	
	2003	_____	10	
	2004	_____	11	
	2005	24,814	12	
Accrual = prior year tax bill rounded up.				
FOR BHF USE ONLY				
	13	FROM R. E. TAX STATEMENT FOR 2005	\$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Bloomington Rehabilitation & Health Care Center COUNTY McLean

FACILITY IDPH LICENSE NUMBER 0047415

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 2005 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 2005.

(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>21-16-128-012</u>	<u>Nursing Home</u>	\$ <u>24,814.02</u>	\$ <u>24,814.02</u>
2. _____	<u>Home Office allocation</u>	\$ _____	\$ <u>1,479.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>24,814.02</u>	\$ <u>26,293.02</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 & 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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.

SEE ACCOUNTANTS' COMPILATION REPORT

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 15,386 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).

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: N/A 2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A 4. Dates Incurred: N/A

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>66,211</u>	<u>2005</u>	<u>\$ 87,500</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	66,211		\$ 87,500	3

SEE ACCOUNTANTS' COMPILATION REPORT

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	78	2005	1972	\$ 528,930	\$	30	\$ 20,800	\$ 20,800	\$ 31,200
5									
6	Allocation								
7	from Home			8,930			391	391	391
8	Office								
Improvement Type**									
9									
10	Land improvement	2005		13,000		15			1,300
11	Sign	2005		458		10			69
12	Sidewalks	2005		3,850		15			128
13	Land improvement booked	2006			867	15	1,041	174	
14	Building booked	2006			20,826	25		(20,826)	
15									
16									
17	2006 Home Office Allocation - Building improvements			531			49	49	49
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
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

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	70
			555,699	21,693	22,281	588	33,137	

SEE ACCOUNTANTS' COMPILATION REPORT

**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	\$ 116,111	\$ 17,575	\$ 17,589	\$ 14	3-7	\$ 26,291	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Allocation from Home Office			4,547	4,547			74
75	TOTALS	\$ 116,111	\$ 17,575	\$ 22,136	\$ 4,561		\$ 26,291	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)	\$ 759,310	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 39,268	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 44,417	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 5,149	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 59,428	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	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		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.

SEE ACCOUNTANTS' COMPILATION REPORT

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? YES NO

If NO, see instructions.

		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	Other: Home Office Allocation				674			5
6								6
7	TOTAL				\$ 674			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: N/A *

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: \$ 34,414 Description: Copier-2873, Dishwasher-856, Compressor-144, Home Office-440, Nursing Equip-30101

(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	<u>N/A</u>				18
19					19
20					20
21	TOTAL		\$	\$	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. _____ /2007 \$ _____

13. _____ /2008 \$ _____

14. _____ /2009 \$ _____

* 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.

SEE ACCOUNTANTS' COMPILATION REPORT

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?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</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. CLINICAL PORTION:</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	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.
- SEE ACCOUNTANTS' COMPILATION REPORT**

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	\$	742	\$ 59,240	\$	742	\$ 59,240	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		81	7,031		81	7,031	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		1,157	89,544	71	1,157	89,615	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39(3)			69	5,500		69	5,500	12
13	Other (specify):									13
14	TOTAL			\$	2,049	\$ 161,315	\$ 71	2,049	\$ 161,386	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Bloomington Rehabilitation & Health Care Center**

0047415

Report Period Beginning: **01/01/2006**

Ending:

12/31/2006

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2006**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 675	\$ 675	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>-0-</u>)	445,044	445,044	3
4	Supply Inventory (priced at <u> </u>)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	12,719	12,719	7
8	Accounts Receivable (owners or related parties)	4,608	4,608	8
9	Other(specify): <u> </u>			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 463,046	\$ 463,046	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	624,351	616,430	14
15	Leasehold Improvements, at Historical Cost		17,839	15
16	Equipment, at Historical Cost	116,569	116,111	16
17	Accumulated Depreciation (book methods)	(47,512)	(59,428)	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): <u> </u>			22
23	Other(specify): <u> </u>			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 693,408	\$ 690,952	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,156,454	\$ 1,153,998	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 555,251	\$ 555,251	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	20,741	20,741	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,265	5,265	31
32	Accrued Real Estate Taxes(Sch.IX-B)	25,000	25,000	32
33	Accrued Interest Payable	7,529	7,529	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Accrued Expenses</u>	10,058	10,059	36
37	<u> </u>			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 623,844	\$ 623,845	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	119,780	119,780	40
41	Bonds Payable	601,096	601,096	41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u> </u>			43
44	<u> </u>			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 720,876	\$ 720,876	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,344,720	\$ 1,344,721	46
47	TOTAL EQUITY(page 18, line 24)	\$ (188,266)	\$ (190,723)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,156,454	\$ 1,153,998	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (17,354)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (17,354)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(170,912)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (170,912)	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)	\$ (188,266)	24 *

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

**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	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 1,450,416	1
2	Discounts and Allowances for all Levels	62,703	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,513,119	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	193,629	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 193,629	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	48,788	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	23	13
14	Non-Patient Meals	1,424	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	59,744	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	10,012	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 119,991	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,115	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,115	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Income</u>	243	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 243	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,830,097	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	409,866	31
32	Health Care	963,587	32
33	General Administration	331,882	33
	B. Capital Expense		
34	Ownership	168,766	34
	C. Ancillary Expense		
35	Special Cost Centers	84,203	35
36	Provider Participation Fee	42,705	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,001,009	40
41	Income before Income Taxes (line 30 minus line 40)**	(170,912)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (170,912)	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.
Entity is a cash basis taxpayer

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Bloomington Rehabilitation & Health Care Center

0047415

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

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	2,123	2,123	\$ 62,866	\$ 29.61	1
2	Assistant Director of Nursing		0			2
3	Registered Nurses	1,954	1,961	45,276	23.09	3
4	Licensed Practical Nurses	9,211	9,280	180,671	19.47	4
5	CNAs & Orderlies	25,318	25,846	307,638	11.90	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,603	3,707	26,470	7.14	9
10	Activity Assistants	441	441	6,740	15.29	10
11	Social Service Workers	137	137	1,638	12.00	11
12	Dietician					12
13	Food Service Supervisor	2,173	2,173	30,533	14.05	13
14	Head Cook			0		14
15	Cook Helpers/Assistants	8,772	8,879	76,421	8.61	15
16	Dishwashers					16
17	Maintenance Workers	3,761	3,793	49,441	13.03	17
18	Housekeepers	6,125	6,174	60,902	9.86	18
19	Laundry	2,661	2,693	7,322	2.72	19
20	Administrator	2,080	2,080	61,087	29.37	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,132	2,132	33,678	15.80	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,905	1,905	21,434	11.25	31
32	Other Health C: <u>CPC</u>	2,025	2,025	44,442	21.94	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	74,419	75,347	\$ 1,016,560 *	\$ 13.49	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	83	\$ 4,174	1,3	35
36	Medical Director	Monthly	7,950	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	181	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) <u>Psychologist</u>	4 visits	4,200	10,3	46
47	<u>Rehab Consultant</u>	29	1,428	10A,3	47
48					48
49	TOTAL (lines 35 - 48)	112	\$ 17,933		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$		50
51	Licensed Practical Nurses	N/A			51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

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	
Janice Kindred	Administrator	0	\$ 61,087	Workers' Compensation Insurance	\$ 23,250	IDPH License Fee	\$ 1,797	
				Unemployment Compensation Insurance	50,881	Advertising: Employee Recruitment	3,112	
				FICA Taxes	74,079	Health Care Worker Background Check (Indicate # of checks performed <u>201</u>)	2,410	
				Employee Health Insurance	3,282	Patient Background Checks		
				Employee Meals	3,860	Misc Dues & Subscriptions	907	
				Illinois Municipal Retirement Fund (IMRF)*		Allocated from Home Office	733	
				Employee Relations	4,566			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 61,087			Less: Public Relations Expense	()	
B. Administrative - Other						Non-allowable advertising	()	
Description			Amount			Yellow page advertising	()	
Management Fee (eliminated in column 7)			\$ 36,500					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 36,500	TOTAL (agree to Schedule V, line 22, col.8)	\$ 159,918	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 8,959	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Altschuler, Melvoin & Glasser, LLP	Accounting		1,600	N/A			Out-of-State Travel	\$
LTC Solutions, Inc.	Computer Services		1,850				In-State Travel	
							Seminar Expense	405
							Allocated from Home Office	550
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 3,450	TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)	\$ 955

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Petersen Health Care, Inc. (Bloomington Rehab)
Provider Number - 0047415
FYE: 12/31/2006

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Total (agree to Schedule V, line 19, column 3) 3,450

Allocated from Home Office

Other Professional Fees-PHC	4,536
Legal	61
Other Professional Fees - PHO	1,867
Legal - PHO	<u>57</u>

Total (agree to Schedule V, line 19, column 8) 9,971

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	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2	N/A											
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bloomington Rehabilitation & Health Care Center# 0047415Report Period Beginning: 01/01/2006Ending: 12/31/2006**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 10,990 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. \$ 42,705
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.

SEE ACCOUNTANTS' COMPILATION REPORT

- (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? No 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. \$ 3,860 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,424
- (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? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- 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? N/A
- 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? No**
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 & Co The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit currently in progress
- (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 \$2500, 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