

Facility Name & ID Number Bloomington Rehabilitation & Health Care Center

0047415 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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			1,769	1,769	8
9	SNF/PED					9
10	ICF	13,633	1,433		15,066	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,633	1,433	1,769	16,835	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 59.13%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 10/01/05

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 1,765

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: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number Bloomington Rehabilitation & Health Care C # 0047415 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	101,263	8,070	1,971	111,304		111,304	3,390	114,694		1
2	Food Purchase		87,889		87,889		87,889	(1,551)	86,338		2
3	Housekeeping	59,775			59,775		59,775	16	59,791		3
4	Laundry	23,723	3,280		27,003		27,003	1	27,004		4
5	Heat and Other Utilities			67,640	67,640		67,640	241	67,881		5
6	Maintenance	44,756	7,694	23,490	75,940		75,940	1,976	77,916		6
7	Other (specify):* <u>Home Off. Ben. All.</u>							2,295	2,295		7
8	TOTAL General Services	229,517	106,933	93,101	429,551		429,551	6,368	435,919		8
	B. Health Care and Programs										
9	Medical Director			7,860	7,860		7,860		7,860		9
10	Nursing and Medical Records	681,920	48,121	17,317	747,358		747,358	5,570	752,928		10
10a	Therapy			167,854	167,854		167,854		167,854		10a
11	Activities	28,060	634	999	29,693		29,693		29,693		11
12	Social Services	12,398			12,398		12,398		12,398		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Off. Ben. All.</u>							2,765	2,765		15
16	TOTAL Health Care and Programs	722,378	48,755	194,030	965,163		965,163	8,335	973,498		16
	C. General Administration										
17	Administrative	62,030		50,000	112,030		112,030	(31,421)	80,609		17
18	Directors Fees										18
19	Professional Services			8,884	8,884		8,884	5,184	14,068		19
20	Dues, Fees, Subscriptions & Promotions			14,242	14,242		14,242	229	14,471		20
21	Clerical & General Office Expenses	33,923	4,842	8,663	47,428		47,428	25,829	73,257		21
22	Employee Benefits & Payroll Taxes			209,507	209,507		209,507		209,507		22
23	Inservice Training & Education			526	526		526	275	801		23
24	Travel and Seminar							437	437		24
25	Other Admin. Staff Transportation			5,057	5,057		5,057	2,849	7,906		25
26	Insurance-Prop.Liab.Malpractice			9,862	9,862		9,862	645	10,507		26
27	Other (specify):* <u>Home Off. Ben. All.</u>							13,578	13,578		27
28	TOTAL General Administration	95,953	4,842	306,741	407,536		407,536	17,605	425,141		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,047,848	160,530	593,872	1,802,250		1,802,250	32,308	1,834,558		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

Bloomington Rehabilitation & Health Care Center

#0047415

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			39,670	39,670		39,670	2,077	41,747			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			54,901	54,901		54,901	37,850	92,751			32
33	Real Estate Taxes			26,199	26,199		26,199	551	26,750			33
34	Rent-Facility & Grounds							34	34			34
35	Rent-Equipment & Vehicles			11,355	11,355		11,355	444	11,799			35
36	Other (specify):*											36
37	TOTAL Ownership			132,125	132,125		132,125	40,956	173,081			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		46,155		46,155		46,155		46,155			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):* Non-allowable Cost	20,000	951	100,777	121,728		121,728	(121,728)				43
44	TOTAL Special Cost Centers	20,000	47,106	143,482	210,588		210,588	(121,728)	88,860			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,067,848	207,636	869,479	2,144,963		2,144,963	(48,464)	2,096,499			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.

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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,600)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,744)	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	(550)	30		9
10	Interest and Other Investment Income	(743)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(511)	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	(7,985)	43		18
19	Entertainment				19
20	Contributions	(50)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(63,331)	43		24
25	Fund Raising, Advertising and Promotional	(38,101)	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 Pg. 5A	(7,254)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (125,869)		\$	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)	83,954	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 83,954		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (41,915)		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	

Bloomington Rehabilitation & Health Care Center

ID# 0047415

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (4,372)	43	1
2	X-Rays-Part A	(1,182)	43	2
3	Offset Miscellaneous Nursing Supplies Revenue	(483)	10	3
4	Resident Flower	(72)	43	4
5	Offset Miscellaneous Office Supplies Revenue	(325)	21	5
6	Offset Chamber of Commerce Dues	(440)	20	6
7	Disallowed Special Events	(380)	43	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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	(7,254)		49

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	1,409	0	2,179	0	0	0	0	0	0	0	3,588	1
2	Food Purchase	(1,600)	49	0	0	0	0	0	0	0	0	0	(1,551)	2
3	Housekeeping	0	16	0	0	0	0	0	0	0	0	0	16	3
4	Laundry	0	1	0	0	0	0	0	0	0	0	0	1	4
5	Heat and Other Utilities	0	241	0	0	0	0	0	0	0	0	0	241	5
6	Maintenance	0	1,962	0	15	0	0	0	0	0	0	0	1,977	6
7	Other (specify):*	0	643	0	1,818	0	0	0	0	0	0	0	2,461	7
8	TOTAL General Services	(1,600)	4,321	0	4,012	0	6,733	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	(483)	3,725	0	2,561	0	0	0	0	0	0	0	5,803	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	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	828	0	2,131	0	0	0	0	0	0	0	2,959	15
16	TOTAL Health Care and Programs	(483)	4,553	0	4,692	0	8,762	16						
	C. General Administration													
17	Administrative	0	(39,513)	0	8,903	0	0	0	0	0	0	0	(30,610)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	2,847	0	2,572	0	0	0	0	0	0	0	5,419	19
20	Fees, Subscriptions & Promotions	(440)	0	617	58	0	0	0	0	0	0	0	235	20
21	Clerical & General Office Expenses	(325)	0	23,879	2,503	0	0	0	0	0	0	0	26,057	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	275	0	0	0	0	0	0	0	0	275	23
24	Travel and Seminar	0	0	437	1	0	0	0	0	0	0	0	438	24
25	Other Admin. Staff Transportation	0	0	1,584	1,392	0	0	0	0	0	0	0	2,976	25
26	Insurance-Prop.Liab.Malpractice	0	0	645	0	0	0	0	0	0	0	0	645	26
27	Other (specify):*	0	0	6,828	7,426	0	0	0	0	0	0	0	14,254	27
28	TOTAL General Administration	(765)	(36,666)	34,265	22,855	0	19,689	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(2,848)	(27,792)	34,265	31,559	0	35,184	29						

STATE OF ILLINOIS

Summary B

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

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(550)	0	1,672	1,051	0	0	0	0	0	0	0	2,173	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(743)	0	2,906	39,264	0	0	0	0	0	0	0	41,427	32
33	Real Estate Taxes	0	0	551	0	0	0	0	0	0	0	0	551	33
34	Rent-Facility & Grounds	0	0	34	0	0	0	0	0	0	0	0	34	34
35	Rent-Equipment & Vehicles	0	0	444	0	0	0	0	0	0	0	0	444	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(1,293)	0	5,607	40,315	0	44,629	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):*	(121,728)	0	0	0	0	0	0	0	0	0	0	(121,728)	43
44	TOTAL Special Cost Centers	(121,728)	0	0	0	0	0	0	0	0	0	0	(121,728)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(125,869)	(27,792)	39,872	71,874	0	(41,915)	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	100	See Attached Schedule 6E		See Attached Sch 6E		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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%	\$ 1,409	\$ 1,409	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	49	49	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	16	16	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	1	1	4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	241	241	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	1,962	1,962	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	643	643	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	3,725	3,725	8
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	828	828	10
11	V	17 Administrative	50,000	Petersen Health Care, Inc.	100.00%	10,487	(39,513)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	2,847	2,847	12
13	V							13
14	Total		\$ 50,000			\$ 22,208	\$ * (27,792)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	20 Dues, Fees, Subs and Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 617	\$	617	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	23,879		23,879	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	275		275	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	437		437	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	1,584		1,584	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	645		645	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	6,828		6,828	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	1,672		1,672	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	2,906		2,906	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	551		551	24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	34		34	25
26	V	35 Rent-Equipment and Vehicles		Petersen Health Care, Inc.	100.00%	444		444	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		\$			\$ 39,872	\$ *	39,872	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1 Dietary	\$	Petersen Health Operations, LLC	100.00%	\$ 2,179	\$	2,179	15
16	V	2 Food		Petersen Health Operations, LLC	100.00%	0		0	16
17	V	3 Housekeeping		Petersen Health Operations, LLC	100.00%	0		0	17
18	V	4 Laundry		Petersen Health Operations, LLC	100.00%	0		0	18
19	V	5 Utilities		Petersen Health Operations, LLC	100.00%	0		0	19
20	V	6 Maintenance		Petersen Health Operations, LLC	100.00%	15		15	20
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	1,818		1,818	21
22	V	10 Nursing and Medical Records		Petersen Health Operations, LLC	100.00%	2,561		2,561	22
23	V	10A Therapy		Petersen Health Operations, LLC	100.00%	0		0	23
24	V	15 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	2,131		2,131	24
25	V	17 Administrative		Petersen Health Operations, LLC	100.00%	8,903		8,903	25
26	V	19 Professional Services		Petersen Health Operations, LLC	100.00%	2,572		2,572	26
27	V	20 Dues, Fees, Subs and Promotions		Petersen Health Operations, LLC	100.00%	58		58	27
28	V	21 Clerical and General Office		Petersen Health Operations, LLC	100.00%	2,503		2,503	28
29	V	23 Inservice Training and Education		Petersen Health Operations, LLC	100.00%	0		0	29
30	V	24 Travel and Seminar		Petersen Health Operations, LLC	100.00%	1		1	30
31	V	25 Other Admin. Staff Transportation		Petersen Health Operations, LLC	100.00%	1,392		1,392	31
32	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Operations, LLC	100.00%	0		0	32
33	V	27 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	7,426		7,426	33
34	V	30 Depreciation		Petersen Health Operations, LLC	100.00%	1,051		1,051	34
35	V	32 Interest		Petersen Health Operations, LLC	100.00%	39,264		39,264	35
36	V	33 Real Estate Taxes		Petersen Health Operations, LLC	100.00%	0		0	36
37	V	34 Rent-Facility and Grounds		Petersen Health Operations, LLC	100.00%	0		0	37
38	V	35 Rent-Equipment and Vehicles		Petersen Health Operations, LLC	100.00%	0		0	38
39	Total		\$			\$ 71,874	\$ *	71,874	39

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

Facility Name & ID Number Bloomington Rehabilitation & Health Care (# 0047415 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	0.69	1.25	Salary	\$ 10,487	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	\$ 10,487		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 Bloomington Rehabilitation & Health Care Center # 0047415 Report Period Beginning: 01/01/2007 Ending: 2/31/2007

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,316,550	66	\$ 110,171	\$ 109,587	16,835	\$ 1,409	1
2	2	Food	Resident Days	1,316,550	66	3,806	0	16,835	49	2
3	3	Housekeeping	Resident Days	1,316,550	66	1,250	0	16,835	16	3
4	4	Laundry	Resident Days	1,316,550	66	73	0	16,835	1	4
5	5	Utilities	Resident Days	1,316,550	66	18,812	0	16,835	241	5
6	6	Maintenance	Resident Days	1,316,550	66	153,468	113,063	16,835	1,962	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	50,271	0	16,835	643	7
8	10	Nursing and Medical Records	Resident Days	1,316,550	66	291,305	286,855	16,835	3,725	8
9	10A	Therapy	Resident Days	1,316,550	66	0	0	16,835	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	64,765	0	16,835	828	10
11	17	Administrative	Resident Days	1,316,550	66	820,116	820,116	16,835	10,487	11
12	19	Professional Services	Resident Days	1,316,550	66	222,628	0	16,835	2,847	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,316,550	66	48,243	0	16,835	617	13
14	21	Clerical and General Office	Resident Days	1,316,550	66	1,867,440	1,544,801	16,835	23,879	14
15	23	Inservice Training & Education	Resident Days	1,316,550	66	21,481	0	16,835	275	15
16	24	Travel and Seminar	Resident Days	1,316,550	66	34,177	0	16,835	437	16
17	25	Other Admin. Staff Transport.	Resident Days	1,316,550	66	123,847	0	16,835	1,584	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,316,550	66	50,427	0	16,835	645	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	533,953	0	16,835	6,828	19
20	30	Depreciation	Resident Days	1,316,550	66	130,767	0	16,835	1,672	20
21	32	Interest	Resident Days	1,316,550	66	227,295	0	16,835	2,906	21
22	33	Real Estate Taxes	Resident Days	1,316,550	66	43,090	0	16,835	551	22
23	34	Rent-Facility and Grounds	Resident Days	1,316,550	66	2,648	0	16,835	34	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,316,550	66	34,690	0	16,835	444	24
25	TOTALS					\$ 4,854,723	\$ 2,874,422		\$ 62,080	25

Facility Name & ID Number Bloomington Rehabilitation & Health Care Center # 0047415 Report Period Beginning: 01/01/2007 Ending: 2/31/2007

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	440,525	23	\$	51,832	16,835	\$ 2,179	1
2	2	Food	Resident Days	440,525	23			16,835		2
3	3	Housekeeping	Resident Days	440,525	23			16,835		3
4	4	Laundry	Resident Days	440,525	23			16,835		4
5	5	Utilities	Resident Days	440,525	23			16,835		5
6	6	Maintenance	Resident Days	440,525	23	358		16,835	15	6
7	7	Mgmt. Allocation of Benefits	Resident Days	440,525	23	43,237		16,835	1,818	7
8	10	Nursing and Medical Records	Resident Days	440,525	23	60,910	60,761	16,835	2,561	8
9	10A	Therapy	Resident Days	440,525	23			16,835		9
10	15	Mgmt. Allocation of Benefits	Resident Days	440,525	23	50,681		16,835	2,131	10
11	17	Administrative	Resident Days	440,525	23	211,751	211,751	16,835	8,903	11
12	19	Professional Services	Resident Days	440,525	23	61,162		16,835	2,572	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	440,525	23	1,373		16,835	58	13
14	21	Clerical and General Office	Resident Days	440,525	23	59,529		16,835	2,503	14
15	23	Inservice Training & Education	Resident Days	440,525	23			16,835		15
16	24	Travel and Seminar	Resident Days	440,525	23	10		16,835	1	16
17	25	Other Admin. Staff Transport.	Resident Days	440,525	23	33,098		16,835	1,392	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	440,525	23			16,835		18
19	27	Mgmt. Allocation of Benefits	Resident Days	440,525	23	176,624		16,835	7,426	19
20	30	Depreciation	Resident Days	440,525	23	24,996		16,835	1,051	20
21	32	Interest	Resident Days	440,525	23	933,842		16,835	39,264	21
22	33	Real Estate Taxes	Resident Days	440,525	23			16,835		22
23	34	Rent-Facility and Grounds	Resident Days	440,525	23			16,835		23
24	35	Rent-Equipment & Vehicles	Resident Days	440,525	23			16,835		24
25	TOTALS					\$ 1,657,571	\$ 324,344		\$ 71,874	25

Facility Name & ID Number Bloomington Rehabilitation & Health Care C

0047415

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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**					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	1/19/07	\$ 550,000	\$ 545,873	12/31/13	Varies	\$ 54,901	1					
2												2					
3							Interest Income Offset				(743)	3					
4							Home Office Allocation-PHO				35,687	4					
5							Home Office Allocation-PHC				2,906	5					
Working Capital																	
6												6					
7												7					
8												8					
9	TOTAL Facility Related						\$ 550,000	\$ 545,873			\$ 92,751	9					
B. Non-Facility Related*																	
10												10					
11												11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$	14					
15	TOTALS (line 9+line14)						\$ 550,000	\$ 545,873			\$ 92,751	15					

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

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

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

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2006 report.		\$	25,000	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.)	2006	\$	25,199	2
3. Under or (over) accrual (line 2 minus line 1).		\$	199	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	26,000	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			551	
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.		\$	26,750	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2002		8	
	2003		9	
	2004		10	
	2005	24,814	11	
	2006	25,199	12	
Accrual based on prior year tax bill.				
FOR BHF USE ONLY				
	13	FROM R. E. TAX STATEMENT FOR 2006	\$	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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 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 2006 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 2006.

(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>Long-Term Care Facility</u>	\$ <u>25,199.00</u>	\$ <u>25,199.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>25,199.00</u>	\$ <u>25,199.00</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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.

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).

N/A

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>66,211</u>	<u>2005</u>	<u>\$ 87,500</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	66,211		\$ 87,500	3

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	\$ 52,000
5									
6									
7	Home Office Allocation			9,386			229	229	
8									
Improvement Type**									
9									
10	Land improvement		2005	13,000		15	867	867	2,167
11	Sign		2005	458		10	46	46	115
12	Sidewalks		2005	3,850		15	257	257	385
13	Roof		2007	9,076		20	454	454	454
14									
15									
16									
17									
18									
19	Building booked				20,826			(20,826)	
20	Building Improvements booked				973			(973)	
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31	2007-Home Office Allocation-Building Improvements			628			37	37	
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

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)		\$ 565,328	\$ 21,799		\$ 22,690	\$ 891	\$ 55,121	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 116,111	\$ 17,735	\$ 16,587	\$ (1,148)	3-7	\$ 42,878	71
72	Current Year Purchases	2,176	136	109	(27)	10	109	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			2,361	2,361			74
75	TOTALS	\$ 118,287	\$ 17,871	\$ 19,057	\$ 1,186		\$ 42,987	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)	\$ 771,115	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 39,670	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 41,747	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,077	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 98,108	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.

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		Home Office Allocation			34			6
7	TOTAL				\$ 34			7

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

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

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 11,799 Description: See 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

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. _____ /2008 \$ _____

13. _____ /2009 \$ _____

14. _____ /2010 \$ _____

* 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.

**Bloomington Rehabilitation & Health Care Center
0047415**

Period Beginning 01/01/2007

Period End 12/31/2007

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$ 6,457
Dishwasher	535
Copier	4,363
Home Office Allocation	444
	<u>11,799</u>

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</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.

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	\$	5,030	\$ 75,443	\$	5,030	\$ 75,443	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		70	1,053		70	1,053	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		6,084	91,258		6,084	91,258	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescripts				46,155		46,155	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Respiratory Therapy	10A(3)			7	100		7	100	13
14	TOTAL			\$	11,191	\$ 167,854	\$ 46,155	11,191	\$ 214,009	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number **Bloomington Rehabilitation & Health Care Center** # **0047415** Report Period Beginning: **01/01/2007** Ending: **12/31/2007**
XV. BALANCE SHEET - Unrestricted Operating Fund. As of **12/31/2007** (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	\$ (648,463)	\$ (648,463)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	536,710	536,710	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	11,733	11,733	6
7	Other Prepaid Expenses	33,884	33,884	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (66,136)	\$ (66,136)	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	100,500	87,500	13
14	Buildings, at Historical Cost	520,000	538,316	14
15	Leasehold Improvements, at Historical Cost	9,076	27,012	15
16	Equipment, at Historical Cost	118,745	118,287	16
17	Accumulated Depreciation (book methods)	(87,182)	(98,108)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 661,139	\$ 673,007	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 595,003	\$ 606,871	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 238,210	\$ 238,210	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	21,364	21,364	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,727	5,727	31
32	Accrued Real Estate Taxes(Sch.IX-B)	26,000	26,000	32
33	Accrued Interest Payable	3,415	3,415	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	18,285	18,285	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 313,001	\$ 313,001	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	545,873	545,873	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>A/P-Prior Owner</u>	1,375	1,375	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 547,248	\$ 547,248	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 860,249	\$ 860,249	46
47	TOTAL EQUITY (page 18, line 24)	\$ (265,246)	\$ (253,378)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 595,003	\$ 606,871	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (188,266)	1
2	Restatements (describe):		2
3	Post Cost Report Audit Adjustments	(3,852)	3
4	Rounding	(1)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (192,119)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(73,127)	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)	\$ (73,127)	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)	\$ (265,246)	24 *

* This must agree with page 17, line 47.

Bloomington Rehabilitation & Health Care Center
0047415
Period Beginning 01/01/2007
Period End 12/31/2007

Schedule 18A

XVI. Statement of Changes in Equity

Beginning Equity Restatements:

Post Cost Report Audit Adjustments

After filing the previous year's State of Illinois Financial and Statistical Report for Long-Term Care Facilities, an adjustment was made to the facility's financial records to properly state bad debt expense. Therefore, an adjustment to the current year's beginning equity is necessary to reconcile the previous year's cost report equity to the current year's equity per books. After this adjustment, cost report equity agrees to book equity on Schedule XVI.

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	\$ 1,581,355	1
2	Discounts and Allowances for all Levels	118,704	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,700,059	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	260,368	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 260,368	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,600	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	97,049	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	4,098	20
21	Other Medical Services	7,111	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 109,858	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	743	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 743	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Revenue</u>	808	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 808	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,071,836	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	429,551	31
32	Health Care	965,163	32
33	General Administration	407,536	33
	B. Capital Expense		
34	Ownership	132,125	34
	C. Ancillary Expense		
35	Special Cost Centers	167,883	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)*	\$ 2,144,963	40
41	Income before Income Taxes (line 30 minus line 40)**	(73,127)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (73,127)	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 a division of a 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.

Bloomington Rehabilitation & Health Care Center
0047415

Period Beginning 01/01/2007

Period End 12/31/2007

Schedule 19A

XVII. INCOME STATEMENT

Line 28a - Other revenue

Medical Supplies

Other

Food

Office Supplies

 -

Facility Name & ID Number Bloomington Rehabilitation & Health Care Center

0047415

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

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	2,152	2,152	\$ 60,171	\$ 27.96	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,128	3,128	69,647	22.27	3
4	Licensed Practical Nurses	9,414	9,691	191,410	19.75	4
5	CNAs & Orderlies	27,247	28,007	312,718	11.17	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,957	2,062	24,890	12.07	9
10	Activity Assistants	177	177	1,630	9.21	10
11	Social Service Workers	970	994	12,398	12.47	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	22,895	11.01	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,978	9,158	78,368	8.56	15
16	Dishwashers					16
17	Maintenance Workers	2,653	2,815	44,756	15.90	17
18	Housekeepers	7,396	7,513	59,775	7.96	18
19	Laundry	2,725	2,826	23,723	8.39	19
20	Administrator	2,080	2,080	62,030	29.82	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,980	2,156	33,923	15.73	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	194	194	2,212	11.40	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Sch. 20A</u>	3,613	3,613	67,302	18.63	33
34	TOTAL (lines 1 - 33)	76,744	78,646	\$ 1,067,848 *	\$ 13.58	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	38	\$ 1,971	1(3)	35
36	Medical Director	Monthly	7,860	9(3)	36
37	Medical Records Consultant	Monthly	720	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,139	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)	38	\$ 11,690		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	336	11,773	10(3)	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	336	\$ 11,773		53

Bloomington Rehabilitation & Health Care Center
 0047415
 Period Beginning 01/01/2007
 Period End 12/31/2007

Schedule 20A

XVIII. Staffing and Salary Costs
Line 32-Other

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	2,080	2,080	45,762	22.00
Marketing	1,387	1,387	20,000	14.42
Transportation	146	146	1,540	10.55
Total Line 32-Other	3,613	3,613	67,302	18.63

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	\$ 62,030	Workers' Compensation Insurance	\$ 13,800	IDPH License Fee	\$ 1,106		
				Unemployment Compensation Insurance	44,768	Advertising: Employee Recruitment	3,416		
				FICA Taxes	78,953	Health Care Worker Background Check (Indicate # of checks performed <u>16</u>)	152		
				Employee Health Insurance	66,336	<u>Center for Medicare/Medicaid Services</u>	4,550		
				Employee Meals		Miscellaneous Dues & Subscriptions	763		
				Illinois Municipal Retirement Fund (IMRF)*		Home Office Allocation	669		
				Employee Relations	5,621	Misc. License & Permits	612		
				Smoking Cessation	29	LTC Solutions License	1,600		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 62,030			IHCA Dues	2,043		
B. Administrative - Other						Less: Public Relations Expense	(440)		
Description			Amount			Non-allowable advertising	()		
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 50,000			Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 50,000	TOTAL (agree to Schedule V, line 22, col.8)		\$ 209,507	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 14,471
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
E-Health Data Solutions	Computer Services		\$ 2,025				Out-of-State Travel	\$	
Verizon North	Computer Services		637						
Comm Net Communciation Sys.	Computer Services		142	N/A			In-State Travel		
McGladrey & Pullen	Accounting Services		6,080						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 8,884	TOTAL		\$	Seminar Expense		
							Home Office Allocation	437	
							Entertainment Expense	()	
							TOTAL (agree to Sch. V, line 24, col. 8)		\$ 437

* Attach copy of IMRF notifications

**See instructions.

Bloomington Rehabilitation & Health Care Center

0047415

Period Beginning

01/01/2007

Period End

12/31/2007

Schedule 21A**XIX. SUPPORT SCHEDULE****C. Professional Services**

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		8,884

Home Office Allocation

Pearl & Associates	Legal	18
Addy Bush & Assoc	Legal	9
Registered Agent Solutions	Legal	2
Heyl, Royster, Voelker & Allen	Legal	41
Duane Morris	Legal	64
Ginoli & Co.	Accountants	2,096
RSM McGladrey	Accountants	113
McGladrey & Pullen	Accountants	172
Emdeon Business Services	Computer Services	45
Advanced Answers on Demand	Computer Services	1,207
Access 2 Go	Computer Services	91
Ivans	Computer Services	405
Kemper Technology	Computer Services	189
Adminastar Federal	Computer Services	23
Logmeln	Computer Services	15
E-Health Data Solutions	Computer Services	118
Julie Breedlove	Computer Services	14
Miscellaneous	Computer Services	14
Amerisearch	Employment Fees	548
Total (agree to Schedule V, line 19, column 8)		<u>14,068</u>

Facility Name & ID Number Bloomington Rehabilitation & Health Care Center# 0047415Report Period Beginning: 01/01/2007Ending: 12/31/2007**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. IHCA-\$2,043
- (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. \$ 8,868 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.
- (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. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,600
- (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 & Company 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 still 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 \$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