

Facility Name & ID Number Charleston Rehabilitation & Health Care Center

0048546 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	45	Skilled (SNF)	45	16,425	1
2		Skilled Pediatric (SNF/PED)			2
3	94	Intermediate (ICF)	94	34,310	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	139	TOTALS	139	50,735	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			2,733	2,733	8
9	SNF/PED					9
10	ICF	14,189	4,973		19,162	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,189	4,973	2,733	21,895	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 43.16%

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 11/28/2006

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

YES

Date 11/28/2006

NO

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

YES

NO

If YES, enter number of beds certified 14 and days of care provided 2,719

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 Charleston Rehabilitation & Health Care Cer # 0048546 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	111,297	9,075	5,063	125,435		125,435	1,832	127,267		1
2	Food Purchase		139,546		139,546		139,546	(3,764)	135,782		2
3	Housekeeping	98,562	17,677		116,239		116,239	30	116,269		3
4	Laundry	33,984	15,179		49,163		49,163	1	49,164		4
5	Heat and Other Utilities			155,555	155,555		155,555	313	155,868		5
6	Maintenance	26,600	12,523	25,548	64,671		64,671	2,679	67,350		6
7	Other (specify):* Home Off. Ben. All.							836	836		7
8	TOTAL General Services	270,443	194,000	186,166	650,609		650,609	1,927	652,536		8
	B. Health Care and Programs										
9	Medical Director			10,200	10,200		10,200		10,200		9
10	Nursing and Medical Records	835,067	93,239	2,153	930,459		930,459	4,329	934,788		10
10a	Therapy			243,036	243,036		243,036		243,036		10a
11	Activities	20,961	595	2,249	23,805		23,805	(7,795)	16,010		11
12	Social Services	20,209	16		20,225		20,225		20,225		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.							1,077	1,077		15
16	TOTAL Health Care and Programs	876,237	93,850	257,638	1,227,725		1,227,725	(2,389)	1,225,336		16
	C. General Administration										
17	Administrative	55,325		56,500	111,825		111,825	(42,861)	68,964		17
18	Directors Fees										18
19	Professional Services			6,111	6,111		6,111	4,995	11,106		19
20	Dues, Fees, Subscriptions & Promotions			5,847	5,847		5,847	157	6,004		20
21	Clerical & General Office Expenses	37,491	5,351	13,291	56,133		56,133	33,721	89,854		21
22	Employee Benefits & Payroll Taxes			253,670	253,670		253,670		253,670		22
23	Inservice Training & Education			26	26		26	394	420		23
24	Travel and Seminar			745	745		745	568	1,313		24
25	Other Admin. Staff Transportation			9,057	9,057		9,057	2,181	11,238		25
26	Insurance-Prop.Liab.Malpractice			7,982	7,982		7,982	970	8,952		26
27	Other (specify):* Home Off. Ben. All.							8,880	8,880		27
28	TOTAL General Administration	92,816	5,351	353,229	451,396		451,396	9,005	460,401		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,239,496	293,201	797,033	2,329,730		2,329,730	8,543	2,338,273		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.

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			126,947	126,947		126,947	(24,336)	102,611			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			179,735	179,735		179,735	7,765	187,500			32
33	Real Estate Taxes			50,187	50,187		50,187	717	50,904			33
34	Rent-Facility & Grounds							44	44			34
35	Rent-Equipment & Vehicles			4,804	4,804		4,804	577	5,381			35
36	Other (specify):*											36
37	TOTAL Ownership			361,673	361,673		361,673	(15,233)	346,440			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		86,684		86,684		86,684		86,684			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			76,103	76,103		76,103		76,103			42
43	Other (specify):* Non-allowable Cost	26,122	1,863	85,386	113,371		113,371	(113,371)				43
44	TOTAL Special Cost Centers	26,122	88,547	161,489	276,158		276,158	(113,371)	162,787			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,265,618	381,748	1,320,195	2,967,561		2,967,561	(120,061)	2,847,500			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	(3,827)	2		4
5	Telephone, TV & Radio in Resident Rooms	(10,638)	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	(26,870)	30		9
10	Interest and Other Investment Income	(179)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(644)	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	(11,960)	43		18
19	Entertainment				19
20	Contributions	(1,000)	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	(46,171)	43		24
25	Fund Raising, Advertising and Promotional	(38,283)	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	(13,783)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (153,355)		\$	30

BHF USE ONLY					
48	49	50	51	52	

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

		1	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)	33,294	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 33,294		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (120,061)		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

Charleston Rehabilitation & Health Care Center

ID# 0048546

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (2,702)	43	1
2	X-Rays-Part A	(1,973)	43	2
3	Offset Miscellaneous Office Supplies Revenue	(129)	21	3
4	Disallowed Dues	(645)	20	4
5	Offset Transportation Revenue	(7,321)	11	5
6	Pet Expense	(474)	11	6
7	Offset Miscellaneous Nursing Supplies Revenue	(539)	10	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	(13,783)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Charleston Rehabilitation & Health Care Center# 0048546

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	1,832	0	0	0	0	0	0	0	0	0	1,832	1
2	Food Purchase	(3,827)	63	0	0	0	0	0	0	0	0	0	(3,764)	2
3	Housekeeping	0	21	0	9	0	0	0	0	0	0	0	30	3
4	Laundry	0	1	0	0	0	0	0	0	0	0	0	1	4
5	Heat and Other Utilities	0	313	0	0	0	0	0	0	0	0	0	313	5
6	Maintenance	0	2,552	0	127	0	0	0	0	0	0	0	2,679	6
7	Other (specify):*	0	836	0	0	0	0	0	0	0	0	0	836	7
8	TOTAL General Services	(3,827)	5,618	0	136	0	1,927	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	(539)	4,845	0	23	0	0	0	0	0	0	0	4,329	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(7,795)	0	0	0	0	0	0	0	0	0	0	(7,795)	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	1,077	0	0	0	0	0	0	0	0	0	1,077	15
16	TOTAL Health Care and Programs	(8,334)	5,922	0	23	0	(2,389)	16						
	C. General Administration													
17	Administrative	0	(42,861)	0	0	0	0	0	0	0	0	0	(42,861)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	3,702	0	1,293	0	0	0	0	0	0	0	4,995	19
20	Fees, Subscriptions & Promotions	(645)	0	802	0	0	0	0	0	0	0	0	157	20
21	Clerical & General Office Expenses	(129)	0	31,057	2,793	0	0	0	0	0	0	0	33,721	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	357	37	0	0	0	0	0	0	0	394	23
24	Travel and Seminar	0	0	568	0	0	0	0	0	0	0	0	568	24
25	Other Admin. Staff Transportation	0	0	2,060	121	0	0	0	0	0	0	0	2,181	25
26	Insurance-Prop.Liab.Malpractice	0	0	839	131	0	0	0	0	0	0	0	970	26
27	Other (specify):*	0	0	8,880	0	0	0	0	0	0	0	0	8,880	27
28	TOTAL General Administration	(774)	(39,159)	44,563	4,375	0	9,005	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(12,935)	(27,619)	44,563	4,534	0	8,543	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Charleston Rehabilitation & Health Care Center # 0048546 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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(26,870)	0	2,175	359	0	0	0	0	0	0	0	(24,336)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(179)	0	3,780	4,164	0	0	0	0	0	0	0	7,765	32
33	Real Estate Taxes	0	0	717	0	0	0	0	0	0	0	0	717	33
34	Rent-Facility & Grounds	0	0	44	0	0	0	0	0	0	0	0	44	34
35	Rent-Equipment & Vehicles	0	0	577	0	0	0	0	0	0	0	0	577	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(27,049)	0	7,293	4,523	0	(15,233)	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):*	(113,371)	0	0	0	0	0	0	0	0	0	0	(113,371)	43
44	TOTAL Special Cost Centers	(113,371)	0	0	0	0	0	0	0	0	0	0	(113,371)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(153,355)	(27,619)	51,856	9,057	0	(120,061)	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:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 1,832	\$ 1,832	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	63	63	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	21	21	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	1	1	4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	313	313	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	2,552	2,552	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	836	836	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	4,845	4,845	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%	1,077	1,077	10
11	V	17 Administrative	56,500	Petersen Health Care, Inc.	100.00%	13,639	(42,861)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	3,702	3,702	12
13	V							13
14	Total		\$ 56,500			\$ 28,881	\$ * (27,619)	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%	\$ 802	\$	802	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	31,057		31,057	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	357		357	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	568		568	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	2,060		2,060	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	839		839	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	8,880		8,880	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	2,175		2,175	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	3,780		3,780	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	717		717	24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	44		44	25
26	V	35 Rent-Equipment and Vehicles		Petersen Health Care, Inc.	100.00%	577		577	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		\$			\$ 51,856	\$ *	51,856	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 <u>Dietary</u>	\$	<u>Petersen Companies, LLC</u>	100.00%	\$ 0	\$	0	15
16	V	2 <u>Food</u>		<u>Petersen Companies, LLC</u>	100.00%	0		0	16
17	V	3 <u>Housekeeping</u>		<u>Petersen Companies, LLC</u>	100.00%	9		9	17
18	V	4 <u>Laundry</u>		<u>Petersen Companies, LLC</u>	100.00%	0		0	18
19	V	5 <u>Utilities</u>		<u>Petersen Companies, LLC</u>	100.00%	0		0	19
20	V	6 <u>Maintenance</u>		<u>Petersen Companies, LLC</u>	100.00%	127		127	20
21	V	7 <u>Mgmt. Allocation of Benefits</u>		<u>Petersen Companies, LLC</u>	100.00%	0		0	21
22	V	10 <u>Nursing and Medical Records</u>		<u>Petersen Companies, LLC</u>	100.00%	23		23	22
23	V	10A <u>Therapy</u>		<u>Petersen Companies, LLC</u>	100.00%	0		0	23
24	V	15 <u>Mgmt. Allocation of Benefits</u>		<u>Petersen Companies, LLC</u>	100.00%	0		0	24
25	V	17 <u>Administrative</u>		<u>Petersen Companies, LLC</u>	100.00%	0		0	25
26	V	19 <u>Professional Services</u>		<u>Petersen Companies, LLC</u>	100.00%	1,293		1,293	26
27	V	20 <u>Dues, Fees, Subs and Promotions</u>		<u>Petersen Companies, LLC</u>	100.00%	0		0	27
28	V	21 <u>Clerical and General Office</u>		<u>Petersen Companies, LLC</u>	100.00%	2,793		2,793	28
29	V	23 <u>Inservice Training and Education</u>		<u>Petersen Companies, LLC</u>	100.00%	37		37	29
30	V	24 <u>Travel and Seminar</u>		<u>Petersen Companies, LLC</u>	100.00%	0		0	30
31	V	25 <u>Other Admin. Staff Transportation</u>		<u>Petersen Companies, LLC</u>	100.00%	121		121	31
32	V	26 <u>Insurance-Prop./Liab/Malpractice</u>		<u>Petersen Companies, LLC</u>	100.00%	131		131	32
33	V	27 <u>Mgmt. Allocation of Benefits</u>		<u>Petersen Companies, LLC</u>	100.00%	0		0	33
34	V	30 <u>Depreciation</u>		<u>Petersen Companies, LLC</u>	100.00%	359		359	34
35	V	32 <u>Interest</u>		<u>Petersen Companies, LLC</u>	100.00%	4,164		4,164	35
36	V	33 <u>Real Estate Taxes</u>		<u>Petersen Companies, LLC</u>	100.00%	0		0	36
37	V	34 <u>Rent-Facility and Grounds</u>		<u>Petersen Companies, LLC</u>	100.00%	0		0	37
38	V	35 <u>Rent-Equipment and Vehicles</u>		<u>Petersen Companies, LLC</u>	100.00%	0		0	38
39	Total		\$			\$ 9,057	\$ *	9,057	39

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

Facility Name & ID Number Charleston Rehabilitation & Health Care Ce # 0048546 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	0.9	1.63	Salary	\$ 13,639	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	\$ 13,639		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 Charleston Rehabilitation & Health Care Center# 0048546

Report Period Beginning:

01/01/2007Ending: 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 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

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	1,316,550	66	\$ 110,171	\$ 109,587	21,895	\$ 1,832	1
2	2	Food	Resident Days	1,316,550	66	3,806	0	21,895	63	2
3	3	Housekeeping	Resident Days	1,316,550	66	1,250	0	21,895	21	3
4	4	Laundry	Resident Days	1,316,550	66	73	0	21,895	1	4
5	5	Utilities	Resident Days	1,316,550	66	18,812	0	21,895	313	5
6	6	Maintenance	Resident Days	1,316,550	66	153,468	113,063	21,895	2,552	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	50,271	0	21,895	836	7
8	10	Nursing and Medical Records	Resident Days	1,316,550	66	291,305	286,855	21,895	4,845	8
9	10A	Therapy	Resident Days	1,316,550	66	0	0	21,895	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	64,765	0	21,895	1,077	10
11	17	Administrative	Resident Days	1,316,550	66	820,116	820,116	21,895	13,639	11
12	19	Professional Services	Resident Days	1,316,550	66	222,628	0	21,895	3,702	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,316,550	66	48,243	0	21,895	802	13
14	21	Clerical and General Office	Resident Days	1,316,550	66	1,867,440	1,544,801	21,895	31,057	14
15	23	Inservice Training & Education	Resident Days	1,316,550	66	21,481	0	21,895	357	15
16	24	Travel and Seminar	Resident Days	1,316,550	66	34,177	0	21,895	568	16
17	25	Other Admin. Staff Transport.	Resident Days	1,316,550	66	123,847	0	21,895	2,060	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,316,550	66	50,427	0	21,895	839	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	533,953	0	21,895	8,880	19
20	30	Depreciation	Resident Days	1,316,550	66	130,767	0	21,895	2,175	20
21	32	Interest	Resident Days	1,316,550	66	227,295	0	21,895	3,780	21
22	33	Real Estate Taxes	Resident Days	1,316,550	66	43,090	0	21,895	717	22
23	34	Rent-Facility and Grounds	Resident Days	1,316,550	66	2,648	0	21,895	44	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,316,550	66	34,690	0	21,895	577	24
25	TOTALS					\$ 4,854,723	\$ 2,874,422		\$ 80,737	25

Facility Name & ID Number Charleston Rehabilitation & Health Care Center# 0048546

Report Period Beginning:

01/01/2007Ending: 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 Companies, 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	179,368	12	\$	21,895	\$	1
2	2	Food	Resident Days	179,368	12		21,895		2
3	3	Housekeeping	Resident Days	179,368	12	70	21,895	9	3
4	4	Laundry	Resident Days	179,368	12		21,895		4
5	5	Utilities	Resident Days	179,368	12		21,895		5
6	6	Maintenance	Resident Days	179,368	12	1,038	21,895	127	6
7	7	Mgmt. Allocation of Benefits	Resident Days	179,368	12		21,895		7
8	10	Nursing and Medical Records	Resident Days	179,368	12	189	21,895	23	8
9	10A	Therapy	Resident Days	179,368	12		21,895		9
10	15	Mgmt. Allocation of Benefits	Resident Days	179,368	12		21,895		10
11	17	Administrative	Resident Days	179,368	12		21,895		11
12	19	Professional Services	Resident Days	179,368	12	10,592	21,895	1,293	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	179,368	12		21,895		13
14	21	Clerical and General Office	Resident Days	179,368	12	22,877	21,895	2,793	14
15	23	Inservice Training & Education	Resident Days	179,368	12	300	21,895	37	15
16	24	Travel and Seminar	Resident Days	179,368	12		21,895		16
17	25	Other Admin. Staff Transport.	Resident Days	179,368	12	993	21,895	121	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	179,368	12	1,070	21,895	131	18
19	27	Mgmt. Allocation of Benefits	Resident Days	179,368	12		21,895		19
20	30	Depreciation	Resident Days	179,368	12	2,941	21,895	359	20
21	32	Interest	Resident Days	179,368	12	34,114	21,895	4,164	21
22	33	Real Estate Taxes	Resident Days	179,368	12		21,895		22
23	34	Rent-Facility and Grounds	Resident Days	179,368	12		21,895		23
24	35	Rent-Equipment & Vehicles	Resident Days	179,368	12		21,895		24
25	TOTALS					\$ 74,184	\$	\$ 9,057	25

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 Charleston Rehabilitation & Health Care Center COUNTY Coles

FACILITY IDPH LICENSE NUMBER 0048546

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>02-2-13403-000</u>	<u>Long-Term Care Facility</u>	\$ <u>41,927.30</u>	\$ <u>41,927.30</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>41,927.30</u>	\$ <u>41,927.30</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.

Facility Name & ID Number Charleston Rehabilitation & Health Care Center

0048546

Report Period Beginning:

01/01/2007 Ending:

12/31/2007

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 35,515 B. General Construction Type: Exterior Brick Frame Concrete Block 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>146,070</u>	<u>2006</u>	<u>\$ 75,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	146,070		\$ 75,000	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	139	2006	1970	\$ 2,029,000	\$	30	\$ 67,633	\$ 67,633	\$ 101,450	4
5										5
6										6
7	Home Office Allocation			12,207			298	298		7
8										8
Improvement Type**										
9	Original Land Improvements		2006	20,000		15	1,333	1,333	1,999	9
10	Landscaping		2006	9,952		15	663	663	995	10
11	Sewer Pipe		2006	4,602		15	307	307	460	11
12	Carpeting-Lobby		2007	9,825		10	491	491	491	12
13	Blinds/Window Treatments		2007	1,807		10	90	90	90	13
14	Fire Alarm		2007	1,384		15	46	46	46	14
15										15
16										16
17										17
18										18
19										19
20										20
21	Land Improvement Booked in GL				2,304			(2,304)		21
22	Building Booked in GL				81,160			(81,160)		22
23	Building Improvement Booked in GL				511			(511)		23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31	2007-Home Office Allocation-Building Improvements			817			49	49		31
32										32
33										33
34										34
35										35
36										36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 2,089,594	\$ 83,975		\$ 70,910	\$ (13,065)	\$ 105,531	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	\$ 291,252	\$ 42,358	\$ 29,125	\$ (13,233)	10	\$ 44,049	71
72	Current Year Purchases	7,775	614	389	(225)	10	389	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			2,187	2,187			74
75	TOTALS	\$ 299,027	\$ 42,972	\$ 31,701	\$ (11,271)		\$ 44,438	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)	\$ 2,463,621	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 126,947	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 102,611	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (24,336)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 149,969	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? 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								5
6		Home Office Allocation			44			6
7	TOTAL				\$ 44			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: \$ 5,381 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.	<u>/2008</u>	\$ _____
13.	<u>/2009</u>	\$ _____
14.	<u>/2010</u>	\$ _____

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

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

Charleston Rehabilitation & Health Care Center

0048546

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

Copier	\$ 3,471
Dishwasher	(135)
Medical Equipment	1,468
Home Office Allocation	<u>577</u>
	<u><u>5,381</u></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	L. 10A, C. 3	hrs	\$	6,744	\$ 101,164	\$	6,744	\$ 101,164	1
2	Licensed Speech and Language Development Therapist	L. 10A ,C. 3	hrs		882	13,223		882	13,223	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L. 10A, C. 3	hrs		8,564	128,462		8,564	128,462	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L. 39, C. 2	# of prescrpts				86,684		86,684	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <u>Respiratory Therapy</u>					187			187	13
14	TOTAL			\$	16,190	\$ 243,036	\$ 86,684	16,190	\$ 329,720	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 Charleston Rehabilitation & Health Care Center

0048546

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	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (16,705)	\$ (16,705)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>N/A</u>)	627,242	627,242	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	19,133	19,133	6
7	Other Prepaid Expenses	15,721	15,721	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): _____			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 645,391	\$ 645,391	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		75,000	13
14	Buildings, at Historical Cost	2,138,554	2,042,024	14
15	Leasehold Improvements, at Historical Cost	12,039	47,570	15
16	Equipment, at Historical Cost	300,003	299,027	16
17	Accumulated Depreciation (book methods)	(147,796)	(149,969)	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>Loan Costs</u>)	9,017	9,017	22
23	Other(specify): _____			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,311,817	\$ 2,322,669	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,957,208	\$ 2,968,060	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 392,932	\$ 392,932	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	57,243	57,243	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,991	2,991	31
32	Accrued Real Estate Taxes(Sch.IX-B)	44,000	44,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	20,670	20,670	36
37	_____			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 517,836	\$ 517,836	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,109,417	2,109,417	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Due to Prior owner</u>	13,241	13,241	43
44	_____			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,122,658	\$ 2,122,658	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,640,494	\$ 2,640,494	46
47	TOTAL EQUITY(page 18, line 24)	\$ 316,714	\$ 327,566	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,957,208	\$ 2,968,060	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	295,254	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) R/E as of 1/1/07-Not Required to Prev Rpt	21,460	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 316,714	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)	\$ 316,714	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Charleston Rehabilitation & Health Care Center # 0048546Report Period Beginning: 01/01/2007Ending: 12/31/2007**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	\$ 2,562,758	1
2	Discounts and Allowances for all Levels	146,095	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,708,853	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	396,292	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 396,292	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	3,827	14
15	Telephone, Television and Radio	2,304	15
16	Rental of Facility Space		16
17	Sale of Drugs	130,117	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	4,273	20
21	Other Medical Services	4,920	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 145,441	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	179	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 179	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	<u>Miscellaneous Revenue-See Sch 19A</u>	12,050	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 12,050	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,262,815	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	650,609	31
32	Health Care	1,227,725	32
33	General Administration	451,396	33
	B. Capital Expense		
34	Ownership	361,673	34
	C. Ancillary Expense		
35	Special Cost Centers	200,055	35
36	Provider Participation Fee	76,103	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,967,561	40
41	Income before Income Taxes (line 30 minus line 40)**	295,254	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 295,254	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.

Charleston Rehabilitation & Health Care Center
0048546

Period Beginning 01/01/2007

Period End 12/31/2007

Schedule 19A

XVII. INCOME STATEMENT

Line 28a - Other revenue

Transportation	7,321
Gain on Sale asset	120
Nursing Supplies	539
Insurance proceeds	3,941
Office Supplies	<u>129</u>

12,050

Facility Name & ID Number Charleston Rehabilitation & Health Care Center

0048546

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	1,467	1,483	\$ 34,816	\$ 23.48	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,661	5,661	125,521	22.17	3
4	Licensed Practical Nurses	10,491	10,639	183,485	17.25	4
5	CNAs & Orderlies	42,301	42,471	453,327	10.67	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,042	2,091	20,961	10.02	9
10	Activity Assistants					10
11	Social Service Workers	1,958	1,998	20,209	10.11	11
12	Dietician					12
13	Food Service Supervisor	2,057	2,057	24,604	11.96	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,804	11,042	86,693	7.85	15
16	Dishwashers					16
17	Maintenance Workers	1,993	2,017	26,600	13.19	17
18	Housekeepers	10,259	10,416	98,562	9.46	18
19	Laundry	4,531	4,568	33,984	7.44	19
20	Administrator	2,080	2,080	55,325	26.60	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,080	2,080	37,491	18.02	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: Care Plan Coord	1,867	1,867	37,918	20.31	32
33	Other(specify) <u>Marketing</u>	1,709	1,709	26,122	15.28	33
34	TOTAL (lines 1 - 33)	101,300	102,179	\$ 1,265,618 *	\$ 12.39	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	Monthly \$ 5,063	L. 1, C. 3	35
36	Medical Director	Monthly 10,200	L. 9, C. 3	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 1,200	L. 10, C. 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)	\$ 16,463		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

Charleston Rehabilitation & Health Care Center
 0048546
 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)		6,111

Non-allowable legal expense

Home Office Allocation

Petersen Health Care, Inc

Pearl & Associates	Legal	24
Addy Bush & Assoc	Legal	12
Registered Agent Solutions	Legal	2
Heyl, Royster, Voelker & Allen	Legal	54
Duane Morris	Legal	83
Ginoli & Co.	Accountants	846
RSM McGladrey	Accountants	147
McGladrey & Pullen	Accountants	224
Emdeon Business Services	Computer Services	58
Advanced Answers on Demand	Computer Services	1,570
Access 2 Go	Computer Services	118
Ivans	Computer Services	104
Kemper Technology	Computer Services	246
Adminastar Federal	Computer Services	31
Logmeln	Computer Services	19
E-Health Data Solutions	Computer Services	154
Miscellaneous Vendors	Miscellaneous	10

Petersen Companies, LLC

Miscellaneous Vendors	Legal	61
Ginoli & Co.	Accountants	518
McGladrey & Pullen	Accountants	714

Non-allowable Legal

Total (agree to Schedule V, line 19, column 8)	<u>11,106</u>
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Facility Name & ID Number Charleston Rehabilitation & Health Care Center# 0048546Report 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? 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 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 21,097 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. \$ 76,103
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. \$ 3,827
- (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? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (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