

Facility Name & ID Number Cisne Rehabilitation & Health Care Center

0047423 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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	35	Intermediate (ICF)	35	12,775	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	35	TOTALS	35	12,775	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					8
9	SNF/PED					9
10	ICF	7,042	1,361		8,403	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,042	1,361		8,403	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.78%

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

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES

NO

Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES

NO

I. On what date did you start providing long term care at this location?

Date started 10/1/2005

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

YES

Date 10/1/2005

NO

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

YES

NO

If YES, enter number of beds certified 0 and days of care provided 0

Medicare Intermediary N/A

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 Cisne Rehabilitation & Health Care Center # 0047423 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	67,849	4,848	5,741	78,438		78,438	1,692	80,130		1
2	Food Purchase		53,907		53,907		53,907	(4,522)	49,385		2
3	Housekeeping	29,427	8,176		37,603		37,603	8	37,611		3
4	Laundry	14,361	4,614		18,975		18,975		18,975		4
5	Heat and Other Utilities			28,662	28,662		28,662	120	28,782		5
6	Maintenance	19	9,240	8,488	17,747		17,747	987	18,734		6
7	Other (specify):* <u>Home Off. Ben. All.</u>							1,146	1,146		7
8	TOTAL General Services	111,656	80,785	42,891	235,332		235,332	(569)	234,763		8
	B. Health Care and Programs										
9	Medical Director			9,900	9,900		9,900		9,900		9
10	Nursing and Medical Records	337,352	23,808	546	361,706		361,706	8	361,714		10
10a	Therapy		187	2,755	2,942		2,942		2,942		10a
11	Activities	13,210	348	8	13,566		13,566		13,566		11
12	Social Services	22,723	4		22,727		22,727		22,727		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Off. Ben. All.</u>							1,380	1,380		15
16	TOTAL Health Care and Programs	373,285	24,347	13,209	410,841		410,841	1,388	412,229		16
	C. General Administration										
17	Administrative	27,536		28,000	55,536		55,536	(18,727)	36,809		17
18	Directors Fees										18
19	Professional Services			8,384	8,384		8,384	2,588	10,972		19
20	Dues, Fees, Subscriptions & Promotions			4,626	4,626		4,626	334	4,960		20
21	Clerical & General Office Expenses	5,229	2,366	10,174	17,769		17,769	12,879	30,648		21
22	Employee Benefits & Payroll Taxes			75,395	75,395		75,395		75,395		22
23	Inservice Training & Education			716	716		716	137	853		23
24	Travel and Seminar							218	218		24
25	Other Admin. Staff Transportation			6,535	6,535		6,535	1,421	7,956		25
26	Insurance-Prop.Liab.Malpractice			6,006	6,006		6,006	322	6,328		26
27	Other (specify):* <u>Home Off. Ben. All.</u>							6,777	6,777		27
28	TOTAL General Administration	32,765	2,366	139,836	174,967		174,967	5,949	180,916		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	517,706	107,498	195,936	821,140		821,140	6,768	827,908		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 Cisne Rehabilitation & Health Care Center

#0047423

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			14,692	14,692		14,692	727	15,419			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			14,835	14,835		14,835	19,101	33,936			32
33	Real Estate Taxes			10,062	10,062		10,062	275	10,337			33
34	Rent-Facility & Grounds							17	17			34
35	Rent-Equipment & Vehicles			2,983	2,983		2,983	221	3,204			35
36	Other (specify):*											36
37	TOTAL Ownership			42,572	42,572		42,572	20,341	62,913			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			19,163	19,163		19,163		19,163			42
43	Other (specify):* Non-allowable Cost		680	5,245	5,925		5,925	(5,925)				43
44	TOTAL Special Cost Centers		680	24,408	25,088		25,088	(5,925)	19,163			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	517,706	108,178	262,916	888,800		888,800	21,184	909,984			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	(4,546)	2		4
5	Telephone, TV & Radio in Resident Rooms	(959)	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	(585)	30		9
10	Interest and Other Investment Income	(163)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(309)	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				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(3,606)	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 <u>See Pg. 5A</u>	(4,239)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (14,407)		\$	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)	35,591	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 35,591		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 21,184		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

Cisne Rehabilitation & Health Care Center

ID# 0047423

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Resident Flower	\$ (280)	43	1
2	Disallowed Special Events	(771)	43	2
3	Offset Miscellaneous Nursing Supplies Revenue	(3,013)	10	3
4	Offset Miscellaneous Office Supplies Revenue	(175)	21	4
5				5
6				6
7				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	(4,239)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Cisne Rehabilitation & Health Care Center# 0047423

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	703	0	989	0	0	0	0	0	0	0	1,692	1
2	Food Purchase	(4,546)	24	0	0	0	0	0	0	0	0	0	(4,522)	2
3	Housekeeping	0	8	0	0	0	0	0	0	0	0	0	8	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	120	0	0	0	0	0	0	0	0	0	120	5
6	Maintenance	0	980	0	7	0	0	0	0	0	0	0	987	6
7	Other (specify):*	0	321	0	825	0	0	0	0	0	0	0	1,146	7
8	TOTAL General Services	(4,546)	2,156	0	1,821	0	(569)	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	(3,013)	1,859	0	1,162	0	0	0	0	0	0	0	8	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	413	0	967	0	0	0	0	0	0	0	1,380	15
16	TOTAL Health Care and Programs	(3,013)	2,272	0	2,129	0	1,388	16						
	C. General Administration													
17	Administrative	0	(22,766)	0	4,039	0	0	0	0	0	0	0	(18,727)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	1,421	0	1,167	0	0	0	0	0	0	0	2,588	19
20	Fees, Subscriptions & Promotions	0	0	308	26	0	0	0	0	0	0	0	334	20
21	Clerical & General Office Expenses	(175)	0	11,919	1,135	0	0	0	0	0	0	0	12,879	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	137	0	0	0	0	0	0	0	0	137	23
24	Travel and Seminar	0	0	218	0	0	0	0	0	0	0	0	218	24
25	Other Admin. Staff Transportation	0	0	790	631	0	0	0	0	0	0	0	1,421	25
26	Insurance-Prop.Liab.Malpractice	0	0	322	0	0	0	0	0	0	0	0	322	26
27	Other (specify):*	0	0	3,408	3,369	0	0	0	0	0	0	0	6,777	27
28	TOTAL General Administration	(175)	(21,345)	17,102	10,367	0	5,949	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(7,734)	(16,917)	17,102	14,317	0	6,768	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number

Cisne Rehabilitation & Health Care Center

0047423

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	(585)	0	835	477	0	0	0	0	0	0	0	727	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(163)	0	1,451	17,813	0	0	0	0	0	0	0	19,101	32
33	Real Estate Taxes	0	0	275	0	0	0	0	0	0	0	0	275	33
34	Rent-Facility & Grounds	0	0	17	0	0	0	0	0	0	0	0	17	34
35	Rent-Equipment & Vehicles	0	0	221	0	0	0	0	0	0	0	0	221	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(748)	0	2,799	18,290	0	20,341	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):*	(5,925)	0	0	0	0	0	0	0	0	0	0	(5,925)	43
44	TOTAL Special Cost Centers	(5,925)	0	0	0	0	0	0	0	0	0	0	(5,925)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(14,407)	(16,917)	19,901	32,607	0	21,184	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%	\$ 703	\$ 703	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	24	24	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	8	8	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	120	120	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	980	980	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	321	321	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	1,859	1,859	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%	413	413	10
11	V	17 Administrative	28,000	Petersen Health Care, Inc.	100.00%	5,234	(22,766)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	1,421	1,421	12
13	V							13
14	Total		\$ 28,000			\$ 11,083	\$ * (16,917)	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%	\$ 308	\$	308	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	11,919		11,919	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	137		137	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	218		218	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	790		790	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	322		322	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	3,408		3,408	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	835		835	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	1,451		1,451	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	275		275	24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	17		17	25
26	V	35 Rent-Equipment and Vehicles		Petersen Health Care, Inc.	100.00%	221		221	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		\$			\$ 19,901	\$ *	19,901	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%	\$ 989	\$ 989	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%	7	7	20
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	825	825	21
22	V	10 Nursing and Medical Records		Petersen Health Operations, LLC	100.00%	1,162	1,162	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%	967	967	24
25	V	17 Administrative		Petersen Health Operations, LLC	100.00%	4,039	4,039	25
26	V	19 Professional Services		Petersen Health Operations, LLC	100.00%	1,167	1,167	26
27	V	20 Dues, Fees, Subs and Promotions		Petersen Health Operations, LLC	100.00%	26	26	27
28	V	21 Clerical and General Office		Petersen Health Operations, LLC	100.00%	1,135	1,135	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%	0	0	30
31	V	25 Other Admin. Staff Transportation		Petersen Health Operations, LLC	100.00%	631	631	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%	3,369	3,369	33
34	V	30 Depreciation		Petersen Health Operations, LLC	100.00%	477	477	34
35	V	32 Interest		Petersen Health Operations, LLC	100.00%	17,813	17,813	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		\$			\$ 32,607	\$ * 32,607	39

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

Facility Name & ID Number Cisne Rehabilitation & Health Care Center # 0047423 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	0.35	0.63	Salary	\$ 5,234	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	\$ 5,234		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 Cisne Rehabilitation & Health Care Center# 0047423

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	8,403	\$ 703	1
2	2	Food	Resident Days	1,316,550	66	3,806	0	8,403	24	2
3	3	Housekeeping	Resident Days	1,316,550	66	1,250	0	8,403	8	3
4	4	Laundry	Resident Days	1,316,550	66	73	0	8,403	0	4
5	5	Utilities	Resident Days	1,316,550	66	18,812	0	8,403	120	5
6	6	Maintenance	Resident Days	1,316,550	66	153,468	113,063	8,403	980	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	50,271	0	8,403	321	7
8	10	Nursing and Medical Records	Resident Days	1,316,550	66	291,305	286,855	8,403	1,859	8
9	10A	Therapy	Resident Days	1,316,550	66	0	0	8,403	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	64,765	0	8,403	413	10
11	17	Administrative	Resident Days	1,316,550	66	820,116	820,116	8,403	5,234	11
12	19	Professional Services	Resident Days	1,316,550	66	222,628	0	8,403	1,421	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,316,550	66	48,243	0	8,403	308	13
14	21	Clerical and General Office	Resident Days	1,316,550	66	1,867,440	1,544,801	8,403	11,919	14
15	23	Inservice Training & Education	Resident Days	1,316,550	66	21,481	0	8,403	137	15
16	24	Travel and Seminar	Resident Days	1,316,550	66	34,177	0	8,403	218	16
17	25	Other Admin. Staff Transport.	Resident Days	1,316,550	66	123,847	0	8,403	790	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,316,550	66	50,427	0	8,403	322	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	533,953	0	8,403	3,408	19
20	30	Depreciation	Resident Days	1,316,550	66	130,767	0	8,403	835	20
21	32	Interest	Resident Days	1,316,550	66	227,295	0	8,403	1,451	21
22	33	Real Estate Taxes	Resident Days	1,316,550	66	43,090	0	8,403	275	22
23	34	Rent-Facility and Grounds	Resident Days	1,316,550	66	2,648	0	8,403	17	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,316,550	66	34,690	0	8,403	221	24
25	TOTALS					\$ 4,854,723	\$ 2,874,422		\$ 30,984	25

Facility Name & ID Number Cisne Rehabilitation & Health Care Center

0047423

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	\$ 51,832	8,403	\$ 989	1
2	2	Food	Resident Days	440,525	23			8,403		2
3	3	Housekeeping	Resident Days	440,525	23			8,403		3
4	4	Laundry	Resident Days	440,525	23			8,403		4
5	5	Utilities	Resident Days	440,525	23			8,403		5
6	6	Maintenance	Resident Days	440,525	23	358		8,403	7	6
7	7	Mgmt. Allocation of Benefits	Resident Days	440,525	23	43,237		8,403	825	7
8	10	Nursing and Medical Records	Resident Days	440,525	23	60,910	60,761	8,403	1,162	8
9	10A	Therapy	Resident Days	440,525	23			8,403		9
10	15	Mgmt. Allocation of Benefits	Resident Days	440,525	23	50,681		8,403	967	10
11	17	Administrative	Resident Days	440,525	23	211,751	211,751	8,403	4,039	11
12	19	Professional Services	Resident Days	440,525	23	61,162		8,403	1,167	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	440,525	23	1,373		8,403	26	13
14	21	Clerical and General Office	Resident Days	440,525	23	59,529		8,403	1,135	14
15	23	Inservice Training & Education	Resident Days	440,525	23			8,403		15
16	24	Travel and Seminar	Resident Days	440,525	23	10		8,403		16
17	25	Other Admin. Staff Transport.	Resident Days	440,525	23	33,098		8,403	631	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	440,525	23			8,403		18
19	27	Mgmt. Allocation of Benefits	Resident Days	440,525	23	176,624		8,403	3,369	19
20	30	Depreciation	Resident Days	440,525	23	24,996		8,403	477	20
21	32	Interest	Resident Days	440,525	23	933,842		8,403	17,813	21
22	33	Real Estate Taxes	Resident Days	440,525	23			8,403		22
23	34	Rent-Facility and Grounds	Resident Days	440,525	23			8,403		23
24	35	Rent-Equipment & Vehicles	Resident Days	440,525	23			8,403		24
25	TOTALS					\$ 1,709,403	\$ 324,344		\$ 32,607	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSES

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.		\$	9,000	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	\$	9,312	2
3. Under or (over) accrual (line 2 minus line 1).		\$	312	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	9,750	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		\$	275	
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.		\$	10,337	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2002		8	
	2003		9	
	2004		10	
	2005	8,946	11	
	2006	9,312	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 Cisne Rehabilitation & Health Care Center COUNTY Wayne

FACILITY IDPH LICENSE NUMBER 0047423

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>03-50-065-006-00</u>	<u>Long-Term Care Facility</u>	\$ <u>9,227.00</u>	\$ <u>9,227.00</u>
2. <u>03-50-065-005</u>	<u>Long-Term Care Facility</u>	\$ <u>85.00</u>	\$ <u>85.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>9,312.00</u>	\$ <u>9,312.00</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.

Facility Name & ID Number Cisne Rehabilitation & Health Care Center

0047423

Report Period Beginning:

01/01/2007 Ending:

12/31/2007

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 9,413 B. General Construction Type: Exterior Brick Veneer 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>75,359</u>	<u>2005</u>	<u>\$ 9,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	75,359		\$ 9,000	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	35	2005	1970	\$ 176,500	\$	25	\$ 7,060	\$ 7,060	\$ 17,650	4
5										5
6										6
7	Home Office Allocation			4,685			114	114		7
8										8
Improvement Type**										
9										9
10	Original Land Improvements	2005		10,000		15	667	667	1,667	10
11	Waterline	2005		1,634		15	109	109	272	11
12	Carpet	2006		1,269		5	254	254	381	12
13	Gutter	2006		2,750		25	110	110	165	13
14	Sewer Line	2007		3,500		20	88	88	88	14
15										15
16										16
17										17
18										18
19										19
20										20
21	Building Booked				7,090			(7,090)		21
22	Building Improvement Booked				1,334			(1,334)		22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31	2007-Home Office Allocation-Building Improvements			313			19	19		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)	\$ 200,651	\$ 8,424		\$ 8,421	\$ (3)	\$ 20,223	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	\$ 39,452	\$ 6,240	\$ 5,759	\$ (481)	5-7	\$ 14,807	71
72	Current Year Purchases	1,194	28	60	32		60	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			1,179	1,179			74
75	TOTALS	\$ 40,646	\$ 6,268	\$ 6,998	\$ 730		\$ 14,867	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)	\$ 250,297	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 14,692	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 15,419	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 727	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 35,090	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		<u>Home Office Allocation</u>			<u>17</u>			6
7	TOTAL				\$ <u>17</u>			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: \$ 3,204 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			<u>N/A</u>		18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____
Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	<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.

Cisne Rehabilitation & Health Care Center

0047423

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	\$	(199)
Dishwasher		528
Copier		2,654
Home Office Allocation		221
		<u>3,204</u>

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	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	\$	49	\$ 737	\$	49	\$ 737	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2)& 10A(3)	hrs		135	2,018	187	135	2,205	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$	184	\$ 2,755	\$ 187	184	\$ 2,942	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 Cisne Rehabilitation & Health Care Center

0047423

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	\$ (500,946)	\$ (500,946)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	146,051	146,051	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	5,418	5,418	6
7	Other Prepaid Expenses	1,418	1,418	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (348,059)	\$ (348,059)	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	24,134	9,000	13
14	Buildings, at Historical Cost	176,500	181,185	14
15	Leasehold Improvements, at Historical Cost	4,019	19,466	15
16	Equipment, at Historical Cost	40,646	40,646	16
17	Accumulated Depreciation (book methods)	(31,322)	(35,090)	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)	\$ 213,977	\$ 215,207	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ (134,082)	\$ (132,852)	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 79,737	\$ 79,737	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	10,572	10,572	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,668	3,668	31
32	Accrued Real Estate Taxes(Sch.IX-B)	9,750	9,750	32
33	Accrued Interest Payable	776	776	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	8,617	8,617	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 113,120	\$ 113,120	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	123,995	123,995	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43		2,560	2,560	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 126,555	\$ 126,555	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 239,675	\$ 239,675	46
47	TOTAL EQUITY(page 18, line 24)	\$ (373,757)	\$ (372,527)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (134,082)	\$ (132,852)	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (267,582)	1
2	Restatements (describe):		2
3	Rounding	(1)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (267,583)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(106,174)	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)	\$ (106,174)	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)	\$ (373,757)	24 *

* This must agree with page 17, line 47.

**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	\$ 774,729	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 774,729	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	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	1,128	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,128	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	163	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 163	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	3,188	28
28a	Meals on Wheels Revenue	3,418	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 6,606	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 782,626	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	235,332	31
32	Health Care	410,841	32
33	General Administration	174,967	33
	B. Capital Expense		
34	Ownership	42,572	34
	C. Ancillary Expense		
35	Special Cost Centers	5,925	35
36	Provider Participation Fee	19,163	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 888,800	40
41	Income before Income Taxes (line 30 minus line 40)**	(106,174)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (106,174)	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.

Facility Name & ID Number Cisne Rehabilitation & Health Care Center

0047423

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	2,080	2,080	\$ 39,548	\$ 19.01	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,610	5,816	103,408	17.78	3
4	Licensed Practical Nurses	3,366	3,490	52,741	15.11	4
5	CNAs & Orderlies	14,347	15,047	141,655	9.41	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,387	1,387	13,187	9.51	9
10	Activity Assistants					10
11	Social Service Workers	2,167	2,167	22,723	10.49	11
12	Dietician					12
13	Food Service Supervisor	2,041	2,121	22,567	10.64	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,843	5,950	45,282	7.61	15
16	Dishwashers					16
17	Maintenance Workers	2	2	19	9.50	17
18	Housekeepers	3,684	3,843	29,427	7.66	18
19	Laundry	1,788	1,904	14,361	7.54	19
20	Administrator	1,473	1,473	27,536	18.69	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	612	614	5,229	8.52	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					31
32	Other Health C: <u>Transportation</u>	3	3	23	7.67	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	44,403	45,897	\$ 517,706 *	\$ 11.28	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	109	\$ 5,741	1(3)	35
36	Medical Director	Monthly	9,900	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	546	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)	109	\$ 16,187		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

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		
Pamela Mix-Bessey	Administrator	0	\$ 17,161	Workers' Compensation Insurance	\$ 7,536	IDPH License Fee	\$ 995		
Jane Owens	Administrator	0	10,375	Unemployment Compensation Insurance	24,526	Advertising: Employee Recruitment			
				FICA Taxes	39,453	Health Care Worker Background Check			
				Employee Health Insurance	(939)	(Indicate # of checks performed)			
				Employee Meals		Patient Background Checks	22 220		
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Dues & Subscriptions	85		
				Employee Relations	3,840	Home Office Allocation	334		
				Employee Retirement	979	Misc. Licenses & Permits-Refund	(317)		
						IHCA Dues	2,043		
						LTC Solutions License	1,600		
						Less: Public Relations Expense	()		
						Non-allowable advertising	()		
						Yellow page advertising	()		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 27,536	TOTAL (agree to Schedule V, line 22, col.8)		\$ 75,395	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 4,960
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 28,000				Out-of-State Travel	\$	
							In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 28,000				Seminar Expense		
							Home Office Allocation	218	
							Entertainment Expense	()	
							(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 8,384	TOTAL		\$	TOTAL	\$ 218	

* Attach copy of IMRF notifications

**See instructions.

Cisne Rehabilitation & Health Care Center

0047423

Period Beginning 01/01/2007

Period End 12/31/2007

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
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Total (agree to Schedule V, line 19, column 3)		8,384
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Home Office Allocation

Pearl & Associates	Legal	9
Addy Bush & Assoc	Legal	5
Registered Agent Solutions	Legal	1
Heyl, Royster, Voelker & Allen	Legal	21
Duane Morris	Legal	32
Ginoli & Co.	Accountants	1,046
RSM McGladrey	Accountants	56
McGladrey & Pullen	Accountants	86
Emdeon Business Services	Computer Services	22
Advanced Answers on Demand	Computer Services	603
Access 2 Go	Computer Services	45
Ivans	Computer Services	202
Kemper Technology	Computer Services	94
Adminastar Federal	Computer Services	12
Logmein	Computer Services	7
E-Health Data Solutions	Computer Services	59
Miscellaneous Vendors	Computer Services	8
Julie Breedlove	Computer Services	7
Amerisearch	Employment Fees	273

Total (agree to Schedule V, line 19, column 8)		<u>10,972</u>
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Facility Name & ID Number Cisne Rehabilitation & Health Care Center# 0047423Report 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. \$ 5,854 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. \$ 19,163
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. \$ 4,546
- (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