

Facility Name & ID Number Enfield Rehabilitation & Health Care Center

0047464 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	49	Intermediate (ICF)	49	17,885	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	49	TOTALS	49	17,885	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	
8	SNF				8
9	SNF/PED				9
10	ICF	12,731	1,142		13,873
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	12,731	1,142		13,873

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.57%

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 10/1/05

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

YES

Date 10/1/05

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 Enfield Rehabilitation & Health Care Center # 0047464 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	90,385	9,936		100,321		100,321	2,793	103,114		1
2	Food Purchase		74,454		74,454		74,454	(863)	73,591		2
3	Housekeeping	71,831	6,835		78,666		78,666	13	78,679		3
4	Laundry	12,085	6,991		19,076		19,076	1	19,077		4
5	Heat and Other Utilities			52,955	52,955		52,955	198	53,153		5
6	Maintenance	18,689	8,842	6,675	34,206		34,206	1,628	35,834		6
7	Other (specify):* <u>Home Off. Ben. All.</u>							1,892	1,892		7
8	TOTAL General Services	192,990	107,058	59,630	359,678		359,678	5,662	365,340		8
	B. Health Care and Programs										
9	Medical Director			5,250	5,250		5,250		5,250		9
10	Nursing and Medical Records	460,063	23,962	498	484,523		484,523	4,988	489,511		10
10a	Therapy		190	3,242	3,432		3,432		3,432		10a
11	Activities	18,122	350	825	19,297		19,297	(855)	18,442		11
12	Social Services	28,606	56		28,662		28,662		28,662		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Off. Ben. All.</u>							2,278	2,278		15
16	TOTAL Health Care and Programs	506,791	24,558	9,815	541,164		541,164	6,411	547,575		16
	C. General Administration										
17	Administrative	31,615		28,000	59,615		59,615	(12,689)	46,926		17
18	Directors Fees										18
19	Professional Services			7,572	7,572		7,572	4,272	11,844		19
20	Dues, Fees, Subscriptions & Promotions			5,229	5,229		5,229	551	5,780		20
21	Clerical & General Office Expenses	15	2,238	6,458	8,711		8,711	21,295	30,006		21
22	Employee Benefits & Payroll Taxes			197,135	197,135		197,135		197,135		22
23	Inservice Training & Education			345	345		345	226	571		23
24	Travel and Seminar							360	360		24
25	Other Admin. Staff Transportation			3,743	3,743		3,743	2,347	6,090		25
26	Insurance-Prop.Liab.Malpractice			8,844	8,844		8,844	531	9,375		26
27	Other (specify):* <u>Home Off. Ben. All.</u>							11,188	11,188		27
28	TOTAL General Administration	31,630	2,238	257,326	291,194		291,194	28,081	319,275		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	731,411	133,854	326,771	1,192,036		1,192,036	40,154	1,232,190		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

Enfield Rehabilitation & Health Care Center

#0047464

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			23,690	23,690		23,690	1,934	25,624			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			23,315	23,315		23,315	31,803	55,118			32
33	Real Estate Taxes			6,345	6,345		6,345	454	6,799			33
34	Rent-Facility & Grounds							28	28			34
35	Rent-Equipment & Vehicles			6,717	6,717		6,717	366	7,083			35
36	Other (specify):*											36
37	TOTAL Ownership			60,067	60,067		60,067	34,585	94,652			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		37		37		37		37			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			26,828	26,828		26,828		26,828			42
43	Other (specify):* Non-allowable Cost		244	964	1,208		1,208	(1,208)				43
44	TOTAL Special Cost Centers		281	27,792	28,073		28,073	(1,208)	26,865			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	731,411	134,135	414,630	1,280,176		1,280,176	73,531	1,353,707			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	(903)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(231)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(439)	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	3,729	43		24
25	Fund Raising, Advertising and Promotional	(3,499)	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	(2,112)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (3,455)		\$	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)	76,986	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 76,986		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 73,531		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

Enfield Rehabilitation & Health Care Center

ID# 0047464

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Resident Flower	\$ (332)	43	1
2	Disallowed Special Events	(667)	43	2
3	Miscellaneous Revenue Offset	(258)	21	3
4	Day Care Revenue Offset	(855)	11	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	(2,112)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Enfield Rehabilitation & Health Care Center# 0047464

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	1,161	0	1,632	0	0	0	0	0	0	0	2,793	1
2	Food Purchase	(903)	40	0	0	0	0	0	0	0	0	0	(863)	2
3	Housekeeping	0	13	0	0	0	0	0	0	0	0	0	13	3
4	Laundry	0	1	0	0	0	0	0	0	0	0	0	1	4
5	Heat and Other Utilities	0	198	0	0	0	0	0	0	0	0	0	198	5
6	Maintenance	0	1,617	0	11	0	0	0	0	0	0	0	1,628	6
7	Other (specify):*	0	530	0	1,362	0	0	0	0	0	0	0	1,892	7
8	TOTAL General Services	(903)	3,560	0	3,005	0	5,662	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	0	3,070	0	1,918	0	0	0	0	0	0	0	4,988	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(855)	0	0	0	0	0	0	0	0	0	0	(855)	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	682	0	1,596	0	0	0	0	0	0	0	2,278	15
16	TOTAL Health Care and Programs	(855)	3,752	0	3,514	0	6,411	16						
	C. General Administration													
17	Administrative	0	(19,358)	0	6,669	0	0	0	0	0	0	0	(12,689)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	2,346	0	1,926	0	0	0	0	0	0	0	4,272	19
20	Fees, Subscriptions & Promotions	0	0	508	43	0	0	0	0	0	0	0	551	20
21	Clerical & General Office Expenses	(258)	0	19,678	1,875	0	0	0	0	0	0	0	21,295	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	226	0	0	0	0	0	0	0	0	226	23
24	Travel and Seminar	0	0	360	0	0	0	0	0	0	0	0	360	24
25	Other Admin. Staff Transportation	0	0	1,305	1,042	0	0	0	0	0	0	0	2,347	25
26	Insurance-Prop.Liab.Malpractice	0	0	531	0	0	0	0	0	0	0	0	531	26
27	Other (specify):*	0	0	5,626	5,562	0	0	0	0	0	0	0	11,188	27
28	TOTAL General Administration	(258)	(17,012)	28,234	17,117	0	28,081	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(2,016)	(9,700)	28,234	23,636	0	40,154	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Enfield Rehabilitation & Health Care Center # 0047464 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	(231)	0	1,378	787	0	0	0	0	0	0	0	1,934	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	2,395	29,408	0	0	0	0	0	0	0	31,803	32
33	Real Estate Taxes	0	0	454	0	0	0	0	0	0	0	0	454	33
34	Rent-Facility & Grounds	0	0	28	0	0	0	0	0	0	0	0	28	34
35	Rent-Equipment & Vehicles	0	0	366	0	0	0	0	0	0	0	0	366	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(231)	0	4,621	30,195	0	34,585	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):*	(1,208)	0	0	0	0	0	0	0	0	0	0	(1,208)	43
44	TOTAL Special Cost Centers	(1,208)	0	0	0	0	0	0	0	0	0	0	(1,208)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(3,455)	(9,700)	32,855	53,831	0	73,531	45						

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark Petersen	100	See Attached Schedule 6E		See Attached Sch 6E		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 1,161	\$ 1,161	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	40	40	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	13	13	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	1	1	4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	198	198	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	1,617	1,617	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	530	530	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	3,070	3,070	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%	682	682	10
11	V	17 Administrative	28,000	Petersen Health Care, Inc.	100.00%	8,642	(19,358)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	2,346	2,346	12
13	V			Petersen Health Care, Inc.	100.00%			13
14	Total		\$ 28,000			\$ 18,300	\$ * (9,700)	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%	\$ 508	\$	508	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	19,678		19,678	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	226		226	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	360		360	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	1,305		1,305	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	531		531	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	5,626		5,626	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	1,378		1,378	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	2,395		2,395	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	454		454	24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	28		28	25
26	V	35 Rent-Equipment and Vehicles		Petersen Health Care, Inc.	100.00%	366		366	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		\$			\$ 32,855	\$ *	32,855	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 Health Operations, LLC</u>	100.00%	\$	\$	1,632	15	
16	V	2 <u>Food</u>		<u>Petersen Health Operations, LLC</u>	100.00%			0	16	
17	V	3 <u>Housekeeping</u>		<u>Petersen Health Operations, LLC</u>	100.00%			0	17	
18	V	4 <u>Laundry</u>		<u>Petersen Health Operations, LLC</u>	100.00%			0	18	
19	V	5 <u>Utilities</u>		<u>Petersen Health Operations, LLC</u>	100.00%			0	19	
20	V	6 <u>Maintenance</u>		<u>Petersen Health Operations, LLC</u>	100.00%			11	20	
21	V	7 <u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Operations, LLC</u>	100.00%			1,362	21	
22	V	10 <u>Nursing and Medical Records</u>		<u>Petersen Health Operations, LLC</u>	100.00%			1,918	22	
23	V	10A <u>Therapy</u>		<u>Petersen Health Operations, LLC</u>	100.00%			0	23	
24	V	15 <u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Operations, LLC</u>	100.00%			1,596	24	
25	V	17 <u>Administrative</u>		<u>Petersen Health Operations, LLC</u>	100.00%			6,669	25	
26	V	19 <u>Professional Services</u>		<u>Petersen Health Operations, LLC</u>	100.00%			1,926	26	
27	V	20 <u>Dues, Fees, Subs and Promotions</u>		<u>Petersen Health Operations, LLC</u>	100.00%			43	27	
28	V	21 <u>Clerical and General Office</u>		<u>Petersen Health Operations, LLC</u>	100.00%			1,875	28	
29	V	23 <u>Inservice Training and Education</u>		<u>Petersen Health Operations, LLC</u>	100.00%			0	29	
30	V	24 <u>Travel and Seminar</u>		<u>Petersen Health Operations, LLC</u>	100.00%			0	30	
31	V	25 <u>Other Admin. Staff Transportation</u>		<u>Petersen Health Operations, LLC</u>	100.00%			1,042	31	
32	V	26 <u>Insurance-Prop./Liab/Malpractice</u>		<u>Petersen Health Operations, LLC</u>	100.00%			0	32	
33	V	27 <u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Operations, LLC</u>	100.00%			5,562	33	
34	V	30 <u>Depreciation</u>		<u>Petersen Health Operations, LLC</u>	100.00%			787	34	
35	V	32 <u>Interest</u>		<u>Petersen Health Operations, LLC</u>	100.00%			29,408	35	
36	V	33 <u>Real Estate Taxes</u>		<u>Petersen Health Operations, LLC</u>	100.00%			0	36	
37	V	34 <u>Rent-Facility and Grounds</u>		<u>Petersen Health Operations, LLC</u>	100.00%			0	37	
38	V	35 <u>Rent-Equipment and Vehicles</u>		<u>Petersen Health Operations, LLC</u>	100.00%			0	38	
39	Total		\$			\$	\$	0	\$ * 53,831	39

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

Facility Name & ID Number Enfield Rehabilitation & Health Care Center # 0047464 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	0.57	1.03	Salary	\$ 8,642	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	\$ 8,642		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 Enfield Rehabilitation & Health Care Center# 0047464

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

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

Name of Related Organization

Petersen Health Care, Inc.

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309) 691-8113

Fax Number

(309) 691-8622

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,316,550	66	\$ 110,171	\$ 109,587	13,873	\$ 1,161	1
2	2	Food	Resident Days	1,316,550	66	3,806	0	13,873	40	2
3	3	Housekeeping	Resident Days	1,316,550	66	1,250	0	13,873	13	3
4	4	Laundry	Resident Days	1,316,550	66	73	0	13,873	1	4
5	5	Utilities	Resident Days	1,316,550	66	18,812	0	13,873	198	5
6	6	Maintenance	Resident Days	1,316,550	66	153,468	113,063	13,873	1,617	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	50,271	0	13,873	530	7
8	10	Nursing and Medical Records	Resident Days	1,316,550	66	291,305	286,855	13,873	3,070	8
9	10A	Therapy	Resident Days	1,316,550	66	0	0	13,873	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	64,765	0	13,873	682	10
11	17	Administrative	Resident Days	1,316,550	66	820,116	820,116	13,873	8,642	11
12	19	Professional Services	Resident Days	1,316,550	66	222,628	0	13,873	2,346	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,316,550	66	48,243	0	13,873	508	13
14	21	Clerical and General Office	Resident Days	1,316,550	66	1,867,440	1,544,801	13,873	19,678	14
15	23	Inservice Training & Education	Resident Days	1,316,550	66	21,481	0	13,873	226	15
16	24	Travel and Seminar	Resident Days	1,316,550	66	34,177	0	13,873	360	16
17	25	Other Admin. Staff Transport.	Resident Days	1,316,550	66	123,847	0	13,873	1,305	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,316,550	66	50,427	0	13,873	531	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	533,953	0	13,873	5,626	19
20	30	Depreciation	Resident Days	1,316,550	66	130,767	0	13,873	1,378	20
21	32	Interest	Resident Days	1,316,550	66	227,295	0	13,873	2,395	21
22	33	Real Estate Taxes	Resident Days	1,316,550	66	43,090	0	13,873	454	22
23	34	Rent-Facility and Grounds	Resident Days	1,316,550	66	2,648	0	13,873	28	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,316,550	66	34,690	0	13,873	366	24
25	TOTALS					\$ 4,854,723	\$ 2,874,422		\$ 51,155	25

Facility Name & ID Number Enfield Rehabilitation & Health Care Center# 0047464

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 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	13,873	\$ 1,632	1
2	2	Food	Resident Days	440,525	23			13,873		2
3	3	Housekeeping	Resident Days	440,525	23			13,873		3
4	4	Laundry	Resident Days	440,525	23			13,873		4
5	5	Utilities	Resident Days	440,525	23			13,873		5
6	6	Maintenance	Resident Days	440,525	23	358		13,873	11	6
7	7	Mgmt. Allocation of Benefits	Resident Days	440,525	23	43,237		13,873	1,362	7
8	10	Nursing and Medical Records	Resident Days	440,525	23	60,910	60,761	13,873	1,918	8
9	10A	Therapy	Resident Days	440,525	23			13,873		9
10	15	Mgmt. Allocation of Benefits	Resident Days	440,525	23	50,681		13,873	1,596	10
11	17	Administrative	Resident Days	440,525	23	211,751	211,751	13,873	6,669	11
12	19	Professional Services	Resident Days	440,525	23	61,162		13,873	1,926	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	440,525	23	1,373		13,873	43	13
14	21	Clerical and General Office	Resident Days	440,525	23	59,529		13,873	1,875	14
15	23	Inservice Training & Education	Resident Days	440,525	23			13,873		15
16	24	Travel and Seminar	Resident Days	440,525	23	10		13,873		16
17	25	Other Admin. Staff Transport.	Resident Days	440,525	23	33,098		13,873	1,042	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	440,525	23			13,873		18
19	27	Mgmt. Allocation of Benefits	Resident Days	440,525	23	176,624		13,873	5,562	19
20	30	Depreciation	Resident Days	440,525	23	24,996		13,873	787	20
21	32	Interest	Resident Days	440,525	23	933,842		13,873	29,408	21
22	33	Real Estate Taxes	Resident Days	440,525	23			13,873		22
23	34	Rent-Facility and Grounds	Resident Days	440,525	23			13,873		23
24	35	Rent-Equipment & Vehicles	Resident Days	440,525	23			13,873		24
25	TOTALS					\$ 1,709,403	\$ 324,344		\$ 53,831	25

Facility Name & ID Number Enfield Rehabilitation & Health Care Center

0047464

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	Name of Lender	2		3	4	5	6		7	8	9	10					
		Related**					Monthly Payment Required	Date of Note					Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
A. Directly Facility Related																	
Long-Term																	
1	LaSalle Bank		X	Mortgage	Varies	1/19/07	\$ 200,000	\$ 198,401	12/31/13	Varies	\$ 23,315	1					
2												2					
3							Home Office Allocation-PHO				29,408	3					
4							Home Office Allocation-PHC				2,395	4					
5												5					
Working Capital																	
6												6					
7												7					
8												8					
9	TOTAL Facility Related						\$ 200,000	\$ 198,401			\$ 55,118	9					
B. Non-Facility Related*																	
10												10					
11												11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$	14					
15	TOTALS (line 9+line14)						\$ 200,000	\$ 198,401			\$ 55,118	15					

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

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

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

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 Enfield Rehabilitation & Health Care Center COUNTY White

FACILITY IDPH LICENSE NUMBER 0047464

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. EN1-017-05	Long-Term Care Facility	\$ 6,095.00	\$ 6,095.00
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>6,095.00</u>	\$ <u>6,095.00</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 10,476 B. General Construction Type: Exterior Brick & Concrete 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>\$ 15,750</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	75,359		\$ 15,750	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	49	2005	1972	\$ 280,250	\$	25	\$ 11,209	\$ 11,209	\$ 28,024
5									
6									
7	Home Office Allocation			7,734			189	189	
8									
Improvement Type**									
9									
10	Original Land		2005	10,000		15	667	667	1,667
11	Door Alarm		2007	1,636		15	55	55	55
12	Air Compressor		2007	1,302		15	43	43	43
13	New Roof		2007	29,725		20	743	743	743
14									
15									
16									
17									
18	Building Booked				11,253			(11,253)	
19	Building Improvement Booked				1,374			(1,374)	
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31	2007-Home Office Allocation-Building Improvements			517			31	31	
32									
33									
34									
35									
36									

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

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

**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	\$ 63,633	\$ 9,510	\$ 8,867	\$ (643)	7-10	\$ 22,877	71
72	Current Year Purchases	15,837	1,553	792	(761)		792	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			3,028	3,028			74
75	TOTALS	\$ 79,470	\$ 11,063	\$ 12,687	\$ 1,624		\$ 23,669	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)	\$ 426,384	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 23,690	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 25,624	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,934	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 54,201	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			28			6
7	TOTAL				\$ 28			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: \$ 7,083 Description: See Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2008 \$ _____

13. _____ /2009 \$ _____

14. _____ /2010 \$ _____

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

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

Enfield Rehabilitation & Health Care Center

0047464

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	\$ 2,422
Dishwasher	463
Copier	3,832
Home Office Allocation	366
	<u>7,083</u>

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	21	\$ 316	\$	21	\$ 316	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		38	570		38	570	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2) & 10A(3)	hrs		157	2,356	190	157	2,546	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescripts				37		37	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			\$	216	\$ 3,242	\$ 227	216	\$ 3,469	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.

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (249,451)	1
2	Restatements (describe):		2
3	Post Cost Report Audit Adjustments	(7,068)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (256,519)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(162,360)	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)	\$ (162,360)	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)	\$ (418,879)	24 *

* This must agree with page 17, line 47.

Enfield Rehabilitation & Health Care Center
0047464
Period Beginning 01/01/2007
Period End 12/31/2007

Schedule 18A

XVI. Statement of Changes in Equity

Beginning Equity Restatements:

Post Cost Report Audit Adjustments

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

Facility Name & ID Number Enfield Rehabilitation & Health Care Center# 0047464Report 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	\$ 1,115,800	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,115,800	3
	B. Ancillary Revenue		
4	Day Care	855	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 855	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	903	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)	\$ 903	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Revenue</u>	258	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 258	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,117,816	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	359,678	31
32	Health Care	541,164	32
33	General Administration	291,194	33
	B. Capital Expense		
34	Ownership	60,067	34
	C. Ancillary Expense		
35	Special Cost Centers	1,245	35
36	Provider Participation Fee	26,828	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,280,176	40
41	Income before Income Taxes (line 30 minus line 40)**	(162,360)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (162,360)	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 Enfield Rehabilitation & Health Care Center

0047464

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	1,995	2,027	\$ 43,871	\$ 21.64	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,136	2,183	41,922	19.20	3
4	Licensed Practical Nurses	8,196	8,287	120,931	14.59	4
5	CNAs & Orderlies	27,622	28,364	253,339	8.93	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,095	2,159	18,122	8.39	10
11	Social Service Workers	2,080	2,080	28,606	13.75	11
12	Dietician					12
13	Food Service Supervisor	1,993	1,993	21,575	10.83	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,382	8,670	68,810	7.94	15
16	Dishwashers					16
17	Maintenance Workers	2,081	2,202	18,689	8.49	17
18	Housekeepers	9,298	9,464	71,831	7.59	18
19	Laundry	1,149	1,240	12,085	9.75	19
20	Administrator	1,907	1,907	31,615	16.58	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2	2	15	7.50	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	68,936	70,578	\$ 731,411 *	\$ 10.36	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	\$		35
36	Medical Director	Monthly 5,250	9(3)	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 498	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)	\$ 5,748		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	
<u>Renee Curtis</u>	<u>Administrator</u>	<u>0</u>	\$ <u>31,615</u>	<u>Workers' Compensation Insurance</u>	\$ <u>11,602</u>	<u>IDPH License Fee</u>	\$ <u>995</u>	
				<u>Unemployment Compensation Insurance</u>	<u>40,007</u>	<u>Advertising: Employee Recruitment</u>	<u>278</u>	
				<u>FICA Taxes</u>	<u>54,953</u>	<u>Health Care Worker Background Check</u>		
				<u>Employee Health Insurance</u>	<u>85,644</u>	(Indicate # of checks performed)		
				<u>Employee Meals</u>		<u>Patient Background Checks</u>	<u>45</u>	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Misc. Licenses & Permits-Refund</u>	<u>(137)</u>	
				<u>Employee Relations</u>	<u>4,314</u>	<u>Home Office Allocation</u>	<u>551</u>	
				<u>Employee Retirement</u>	<u>254</u>	<u>LTC Solutions License</u>	<u>1,600</u>	
				<u>Smoking Cessation</u>	<u>361</u>	<u>IHCA Dues</u>	<u>2,043</u>	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ <u>31,615</u>					
(List each licensed administrator separately.)								
B. Administrative - Other								
Description			Amount					
<u>Management Fees-See Page 6, Eliminated on P 3, C 7</u>			\$ <u>28,000</u>					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ <u>28,000</u>					
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
<u>E-Health Data Solutions</u>	<u>Computer Services</u>		\$ <u>2,025</u>				<u>Out-of-State Travel</u>	\$
<u>Hamilton County Comm.</u>	<u>Computer Services</u>		<u>855</u>					
<u>Verizon North</u>	<u>Computer Services</u>		<u>262</u>	<u>N/A</u>			<u>In-State Travel</u>	
<u>McGladrey & Pullen, LLC</u>	<u>Accounting Services</u>		<u>4,430</u>					
							<u>Seminar Expense</u>	
							<u>Home Office Allocation</u>	<u>360</u>
							<u>Entertainment Expense</u>	()
TOTAL (agree to Schedule V, line 19, column 3)			\$ <u>7,572</u>	TOTAL			(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)							TOTAL	

* Attach copy of IMRF notifications

**See instructions.

Enfield Rehabilitation & Health Care Center
0047464
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)		7,572

Home Office Allocation

Pearl & Associates	Legal	15
Addy Bush & Assoc	Legal	8
Registered Agent Solutions	Legal	1
Heyl, Royster, Voelker & Allen	Legal	34
Duane Morris	Legal	53
Ginoli & Co.	Accountants	1,727
RSM McGladrey	Accountants	93
McGladrey & Pullen	Accountants	142
Emdeon Business Services	Computer Services	37
Advanced Answers on Demand	Computer Services	995
Access 2 Go	Computer Services	75
Ivans	Computer Services	333
Kemper Technology	Computer Services	156
Adminastar Federal	Computer Services	19
Logmein	Computer Services	12
E-Health Data Solutions	Computer Services	98
Miscellaneous Vendors	Computer Services	11
Julie Breedlove	Computer Services	12
Amerisearch	Employment Fees	451
Total (agree to Schedule V, line 19, column 8)		<u>11,844</u>

Facility Name & ID Number Enfield Rehabilitation & Health Care Center# 0047464Report 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. \$ 7,400 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. \$ 26,828
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. \$ 903
- (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