

Facility Name & ID Number McLeansboro Rehabilitation & Health Care Center

0047498 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	43	Skilled (SNF)	43	15,695	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	43	TOTALS	43	15,695	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	9,532	2,386	2,011	13,929	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,532	2,386	2,011	13,929	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.75%

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 43 and days of care provided 2,011

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL 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 McLeansboro Rehabilitation & Health Care (# 0047498 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	101,104	4,925		106,029		106,029	2,805	108,834		1
2	Food Purchase		69,062		69,062		69,062	(1,105)	67,957		2
3	Housekeeping	39,589	5,993		45,582		45,582	13	45,595		3
4	Laundry	21,451	8,867		30,318		30,318	1	30,319		4
5	Heat and Other Utilities			55,349	55,349		55,349	199	55,548		5
6	Maintenance	30,619	4,950	12,356	47,925		47,925	1,635	49,560		6
7	Other (specify):* Home Off. Ben. All.							1,899	1,899		7
8	TOTAL General Services	192,763	93,797	67,705	354,265		354,265	5,447	359,712		8
	B. Health Care and Programs										
9	Medical Director			9,250	9,250		9,250		9,250		9
10	Nursing and Medical Records	505,782	26,483	645	532,910		532,910	(762)	532,148		10
10a	Therapy		159	163,885	164,044		164,044		164,044		10a
11	Activities	18,271	542	1,220	20,033		20,033		20,033		11
12	Social Services	23,337	19	570	23,926		23,926		23,926		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.							13,522	13,522		15
16	TOTAL Health Care and Programs	547,390	27,203	175,570	750,163		750,163	12,760	762,923		16
	C. General Administration										
17	Administrative	39,215		50,000	89,215		89,215	(34,628)	54,587		17
18	Directors Fees										18
19	Professional Services			8,427	8,427		8,427	4,289	12,716		19
20	Dues, Fees, Subscriptions & Promotions			5,639	5,639		5,639	403	6,042		20
21	Clerical & General Office Expenses	30,715	3,267	7,032	41,014		41,014	21,473	62,487		21
22	Employee Benefits & Payroll Taxes			210,954	210,954		210,954		210,954		22
23	Inservice Training & Education			1,751	1,751		1,751	227	1,978		23
24	Travel and Seminar			65	65		65	362	427		24
25	Other Admin. Staff Transportation			6,699	6,699		6,699	2,357	9,056		25
26	Insurance-Prop.Liab.Malpractice			8,480	8,480		8,480	533	9,013		26
27	Other (specify):* Home Off. Ben. All.										27
28	TOTAL General Administration	69,930	3,267	299,047	372,244		372,244	(4,984)	367,260		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	810,083	124,267	542,322	1,476,672		1,476,672	13,223	1,489,895		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			56,464	56,464		56,464	(196)	56,268			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			66,823	66,823		66,823	31,932	98,755			32
33	Real Estate Taxes			7,488	7,488		7,488	456	7,944			33
34	Rent-Facility & Grounds							28	28			34
35	Rent-Equipment & Vehicles			9,241	9,241		9,241	367	9,608			35
36	Other (specify):*											36
37	TOTAL Ownership			140,016	140,016		140,016	32,587	172,603			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		50,420		50,420		50,420		50,420			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			23,543	23,543		23,543		23,543			42
43	Other (specify):* Non-allowable Cost	2,809	24	64,638	67,471		67,471	(67,471)				43
44	TOTAL Special Cost Centers	2,809	50,444	88,181	141,434		141,434	(67,471)	73,963			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	812,892	174,711	770,519	1,758,122		1,758,122	(21,661)	1,736,461			45

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

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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,145)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,925)	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	(2,369)	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	(444)	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	(200)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(45,347)	43		24
25	Fund Raising, Advertising and Promotional	(4,736)	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>	(19,905)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (77,071)		\$	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)	55,410	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 55,410		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (21,661)		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

McLeansboro Rehabilitation & Health Care Center

ID# 0047498

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (11,932)	43	1
2	X-Rays-Part A	(714)	43	2
3	Offset Miscellaneous Nursing Supplies Revenue	(5,770)	10	3
4	Resident Flowers	(232)	2	4
5	Offset Miscellaneous Office Supplies Revenue	(166)	21	5
6	Offset Chamber of Commerce Dues	(150)	20	6
7	Disallowed Special Events	(881)	43	7
8	Vending Machine Expense	(60)	43	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	(19,905)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number McLeansboro Rehabilitation & Health Care Center# 0047498

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	1,166	0	1,639	0	0	0	0	0	0	0	2,805	1
2	Food Purchase	(1,377)	40	0	0	0	0	0	0	0	0	0	(1,337)	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	199	0	0	0	0	0	0	0	0	0	199	5
6	Maintenance	0	1,624	0	11	0	0	0	0	0	0	0	1,635	6
7	Other (specify):*	0	532	0	1,367	0	0	0	0	0	0	0	1,899	7
8	TOTAL General Services	(1,377)	3,575	0	3,017	0	5,215	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	(5,770)	3,082	0	1,926	0	0	0	0	0	0	0	(762)	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	685	0	1,603	0	0	0	0	0	0	0	2,288	15
16	TOTAL Health Care and Programs	(5,770)	3,767	0	3,529	0	1,526	16						
	C. General Administration													
17	Administrative	0	(41,323)	0	6,695	0	0	0	0	0	0	0	(34,628)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	2,355	0	1,934	0	0	0	0	0	0	0	4,289	19
20	Fees, Subscriptions & Promotions	(150)	0	510	43	0	0	0	0	0	0	0	403	20
21	Clerical & General Office Expenses	(166)	0	19,757	1,882	0	0	0	0	0	0	0	21,473	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	227	0	0	0	0	0	0	0	0	227	23
24	Travel and Seminar	0	0	362	0	0	0	0	0	0	0	0	362	24
25	Other Admin. Staff Transportation	0	0	1,310	1,047	0	0	0	0	0	0	0	2,357	25
26	Insurance-Prop.Liab.Malpractice	0	0	533	0	0	0	0	0	0	0	0	533	26
27	Other (specify):*	0	0	5,649	5,585	0	0	0	0	0	0	0	11,234	27
28	TOTAL General Administration	(316)	(38,968)	28,348	17,186	0	6,250	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(7,463)	(31,626)	28,348	23,732	0	12,991	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number McLeansboro Rehabilitation & Health Care Center # 0047498 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(2,369)	0	1,383	790	0	0	0	0	0	0	0	(196)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	2,405	29,527	0	0	0	0	0	0	0	31,932	32
33	Real Estate Taxes	0	0	456	0	0	0	0	0	0	0	0	456	33
34	Rent-Facility & Grounds	0	0	28	0	0	0	0	0	0	0	0	28	34
35	Rent-Equipment & Vehicles	0	0	367	0	0	0	0	0	0	0	0	367	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(2,369)	0	4,639	30,317	0	32,587	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):*	(67,239)	0	0	0	0	0	0	0	0	0	0	(67,239)	43
44	TOTAL Special Cost Centers	(67,239)	0	0	0	0	0	0	0	0	0	0	(67,239)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(77,071)	(31,626)	32,987	54,049	0	(21,661)	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%	\$ 1,166	\$ 1,166	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%	199	199	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	1,624	1,624	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	532	532	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	3,082	3,082	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%	685	685	10
11	V	17 Administrative	50,000	Petersen Health Care, Inc.	100.00%	8,677	(41,323)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	2,355	2,355	12
13	V							13
14	Total		\$ 50,000			\$ 18,374	\$ * (31,626)	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%	\$ 510	\$	510	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	19,757		19,757	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	227		227	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	362		362	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	1,310		1,310	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	533		533	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	5,649		5,649	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	1,383		1,383	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	2,405		2,405	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	456		456	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%	367		367	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		\$			\$ 32,987	\$ *	32,987	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%	\$ 1,639	\$	1,639	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%	11		11	20
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	1,367		1,367	21
22	V	10 Nursing and Medical Records		Petersen Health Operations, LLC	100.00%	1,926		1,926	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%	1,603		1,603	24
25	V	17 Administrative		Petersen Health Operations, LLC	100.00%	6,695		6,695	25
26	V	19 Professional Services		Petersen Health Operations, LLC	100.00%	1,934		1,934	26
27	V	20 Dues, Fees, Subs and Promotions		Petersen Health Operations, LLC	100.00%	43		43	27
28	V	21 Clerical and General Office		Petersen Health Operations, LLC	100.00%	1,882		1,882	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%	1,047		1,047	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%	5,585		5,585	33
34	V	30 Depreciation		Petersen Health Operations, LLC	100.00%	790		790	34
35	V	32 Interest		Petersen Health Operations, LLC	100.00%	29,527		29,527	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		\$			\$ 54,049	\$ *	54,049	39

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

Facility Name & ID Number

#

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	1.04	Salary	\$ 8,677	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	\$ 8,677		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 McLeansboro Rehabilitation & Health Care Center # 0047498 Report Period Beginning: 01/01/2007 Ending: 2/31/2007

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,316,550	66	\$ 110,171	\$ 109,587	13,929	\$ 1,166	1
2	2	Food	Resident Days	1,316,550	66	3,806	0	13,929	40	2
3	3	Housekeeping	Resident Days	1,316,550	66	1,250	0	13,929	13	3
4	4	Laundry	Resident Days	1,316,550	66	73	0	13,929	1	4
5	5	Utilities	Resident Days	1,316,550	66	18,812	0	13,929	199	5
6	6	Maintenance	Resident Days	1,316,550	66	153,468	113,063	13,929	1,624	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	50,271	0	13,929	532	7
8	10	Nursing and Medical Records	Resident Days	1,316,550	66	291,305	286,855	13,929	3,082	8
9	10A	Therapy	Resident Days	1,316,550	66	0	0	13,929	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	64,765	0	13,929	685	10
11	17	Administrative	Resident Days	1,316,550	66	820,116	820,116	13,929	8,677	11
12	19	Professional Services	Resident Days	1,316,550	66	222,628	0	13,929	2,355	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,316,550	66	48,243	0	13,929	510	13
14	21	Clerical and General Office	Resident Days	1,316,550	66	1,867,440	1,544,801	13,929	19,757	14
15	23	Inservice Training & Education	Resident Days	1,316,550	66	21,481	0	13,929	227	15
16	24	Travel and Seminar	Resident Days	1,316,550	66	34,177	0	13,929	362	16
17	25	Other Admin. Staff Transport.	Resident Days	1,316,550	66	123,847	0	13,929	1,310	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,316,550	66	50,427	0	13,929	533	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	533,953	0	13,929	5,649	19
20	30	Depreciation	Resident Days	1,316,550	66	130,767	0	13,929	1,383	20
21	32	Interest	Resident Days	1,316,550	66	227,295	0	13,929	2,405	21
22	33	Real Estate Taxes	Resident Days	1,316,550	66	43,090	0	13,929	456	22
23	34	Rent-Facility and Grounds	Resident Days	1,316,550	66	2,648	0	13,929	28	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,316,550	66	34,690	0	13,929	367	24
25	TOTALS					\$ 4,854,723	\$ 2,874,422		\$ 51,361	25

Facility Name & ID Number McLeansboro Rehabilitation & Health Care Center# 0047498

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	\$ 51,833	\$ 51,832	13,929	\$ 1,639	1
2	2	Food	Resident Days	440,525	23			13,929		2
3	3	Housekeeping	Resident Days	440,525	23			13,929		3
4	4	Laundry	Resident Days	440,525	23			13,929		4
5	5	Utilities	Resident Days	440,525	23			13,929		5
6	6	Maintenance	Resident Days	440,525	23	358		13,929	11	6
7	7	Mgmt. Allocation of Benefits	Resident Days	440,525	23	43,235		13,929	1,367	7
8	10	Nursing and Medical Records	Resident Days	440,525	23	60,909	60,761	13,929	1,926	8
9	10A	Therapy	Resident Days	440,525	23			13,929		9
10	15	Mgmt. Allocation of Benefits	Resident Days	440,525	23	50,682		13,929	1,603	10
11	17	Administrative	Resident Days	440,525	23	211,753	211,751	13,929	6,695	11
12	19	Professional Services	Resident Days	440,525	23	61,162		13,929	1,934	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	440,525	23	1,373		13,929	43	13
14	21	Clerical and General Office	Resident Days	440,525	23	59,528		13,929	1,882	14
15	23	Inservice Training & Education	Resident Days	440,525	23			13,929		15
16	24	Travel and Seminar	Resident Days	440,525	23	12		13,929		16
17	25	Other Admin. Staff Transport.	Resident Days	440,525	23	33,100		13,929	1,047	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	440,525	23			13,929		18
19	27	Mgmt. Allocation of Benefits	Resident Days	440,525	23	176,626		13,929	5,585	19
20	30	Depreciation	Resident Days	440,525	23	24,998		13,929	790	20
21	32	Interest	Resident Days	440,525	23	933,841		13,929	29,527	21
22	33	Real Estate Taxes	Resident Days	440,525	23			13,929		22
23	34	Rent-Facility and Grounds	Resident Days	440,525	23			13,929		23
24	35	Rent-Equipment & Vehicles	Resident Days	440,525	23			13,929		24
25	TOTALS					\$ 1,709,410	\$ 324,344		\$ 54,049	25

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	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	LaSalle Bank		X	Mortgage	Varies	1/19/07	\$ 650,000	\$ 645,063	12/31/13	Varies	\$ 66,823	1								
2												2								
3							Home Office Allocation-PHC				2,405	3								
4							Home Office Allocation-PHO				29,527	4								
5												5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related						\$ 650,000	\$ 645,063			\$ 98,755	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 650,000	\$ 645,063			\$ 98,755	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 McLeansboro Rehabilitation & Health Care Center COUNTY Hamilton

FACILITY IDPH LICENSE NUMBER 0047498

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>07-154-005-00</u>	<u>Long-Term Care Facility</u>	\$ <u>6,965.00</u>	\$ <u>6,965.00</u>
2. <u>07-154-007-00</u>	<u>Long-Term Care Facility</u>	\$ <u>73.00</u>	\$ <u>73.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>7,038.00</u>	\$ <u>7,038.00</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: 11,840 B. General Construction Type: Exterior Brick Frame Fire Resistant 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>56,628</u>	<u>2005</u>	<u>\$ 40,500</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	56,628		\$ 40,500	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	73	2005	1973	\$ 727,500	\$	25	\$ 29,100	\$ 29,100	\$ 72,750	4
5										5
6										6
7	Home Office Allocation			7,765			190	190		7
8										8
Improvement Type**										
9										9
10	Original Land Improvements	2005		14,000		15	933	933	2,333	10
11	Water Tap	2007		2,500		15	83	83	83	11
12	Sprinkler System	2007		39,152		15	1,305	1,305	1,305	12
13	Grease Trap	2007		4,075		15	136	136	136	13
14	Drain Tank	2007		462		15	15	15	15	14
15	Fire Alarm	2007		4,283		15	143	143	143	15
16										16
17										17
18										18
19										19
20	Building Booked				29,185			(29,185)		20
21	Building Improvements Booked				3,164			(3,164)		21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31	2007-Home Office Allocation-Building Improvements			520			31	31		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)		\$ 800,257	\$ 32,349		\$ 31,936	\$ (413)	\$ 76,765	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	\$ 155,471	\$ 23,663	\$ 22,210	\$ (1,453)	3-7	\$ 55,251	71
72	Current Year Purchases	3,392	452	170	(282)	10	170	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			1,952	1,952			74
75	TOTALS	\$ 158,863	\$ 24,115	\$ 24,332	\$ 217		\$ 55,421	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)	\$ 999,620	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 56,464	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 56,268	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (196)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 132,186	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: \$ 9,608 Description: See Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____
Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2008</u>	\$ _____
13.	<u>/2009</u>	\$ _____
14.	<u>/2010</u>	\$ _____

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

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

McLeansboro Rehabilitation & Health Care Center

0047498

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	\$	4,789
Dishwasher		583
Copier		3,869
Home Office Allocation		367
		<u>9,608</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	\$	4,552	\$ 68,273	\$	4,552	\$ 68,273	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,040	15,598		1,040	15,598	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		5,334	80,014	159	5,334	80,173	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				50,420		50,420	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			\$	10,926	\$ 163,885	\$ 50,579	10,926	\$ 214,464	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 **McLeansboro Rehabilitation & Health Care Center** # **0047498** 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	\$ (320,057)	\$ (320,057)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>N/A</u>)	508,721	508,721	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	7,814	7,814	6
7	Other Prepaid Expenses	5,854	5,854	7
8	Accounts Receivable (owners or related parties)	(55,544)	(55,544)	8
9	Other(specify): _____			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 146,788	\$ 146,788	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	57,000	40,500	13
14	Buildings, at Historical Cost	727,500	735,265	14
15	Leasehold Improvements, at Historical Cost	47,972	64,992	15
16	Equipment, at Historical Cost	158,863	158,863	16
17	Accumulated Depreciation (book methods)	(118,744)	(132,186)	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): <u>Security Deposits</u>			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 872,591	\$ 867,434	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,019,379	\$ 1,014,222	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 248,749	\$ 248,749	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	18,666	18,666	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,642	5,642	31
32	Accrued Real Estate Taxes(Sch.IX-B)	7,250	7,250	32
33	Accrued Interest Payable	4,035	4,035	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Payroll Withholding</u>	12,359	12,359	36
37	_____			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 296,701	\$ 296,701	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	645,063	645,063	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	_____			43
44	_____			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 645,063	\$ 645,063	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 941,764	\$ 941,764	46
47	TOTAL EQUITY(page 18, line 24)	\$ 77,615	\$ 72,458	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,019,379	\$ 1,014,222	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 9,515	1
2	Restatements (describe):		2
3	<u>Rounding</u>	3	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 9,518	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	68,097	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)	\$ 68,097	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)	\$ 77,615	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number McLeansboro Rehabilitation & Health Care Center # 0047498Report 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	\$ 1,337,454	1
2	Discounts and Allowances for all Levels	143,122	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,480,576	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	234,374	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 234,374	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	1,145	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	77,008	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	24,690	20
21	Other Medical Services	2,490	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 105,333	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>	5,936	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 5,936	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,826,219	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	354,265	31
32	Health Care	750,163	32
33	General Administration	372,244	33
	B. Capital Expense		
34	Ownership	140,016	34
	C. Ancillary Expense		
35	Special Cost Centers	117,891	35
36	Provider Participation Fee	23,543	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,758,122	40
41	Income before Income Taxes (line 30 minus line 40)**	68,097	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 68,097	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

#

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	1,529	1,529	\$ 33,773	\$ 22.09	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,185	1,205	21,350	17.72	3
4	Licensed Practical Nurses	12,505	13,034	186,774	14.33	4
5	CNAs & Orderlies	30,449	31,341	248,475	7.93	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,295	1,320	13,811	10.46	9
10	Activity Assistants	555	555	4,460	8.04	10
11	Social Service Workers	1,812	1,973	23,337	11.83	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	23,706	11.40	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,293	9,691	77,398	7.99	15
16	Dishwashers					16
17	Maintenance Workers	2,010	2,170	30,619	14.11	17
18	Housekeepers	4,990	5,087	39,589	7.78	18
19	Laundry	2,606	2,752	21,451	7.79	19
20	Administrator	1,324	1,364	39,215	28.75	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,107	2,297	30,715	13.37	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: Care Plan Coord.	867	907	15,410	16.99	32
33	Other(specify) Marketing	229	229	2,809	12.27	33
34	TOTAL (lines 1 - 33)	74,836	77,534	\$ 812,892 *	\$ 10.48	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 9,250	9(3)	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 543	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	Monthly 585	11(3)	44
45	Social Service Consultant	Monthly 570	12(3)	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 10,948		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

Facility Name & ID Number

#

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	
Juli Piper	Administrator	0	\$ 39,215	Workers' Compensation Insurance	\$ 12,224	IDPH License Fee	\$ 995	
				Unemployment Compensation Insurance	42,223	Advertising: Employee Recruitment	437	
				FICA Taxes	61,003	Health Care Worker Background Check (Indicate # of checks performed)		
				Employee Health Insurance	91,553	Patient Background Checks	12 120	
				Employee Meals		Miscellaneous Dues & Subscriptions	165	
				Illinois Municipal Retirement Fund (IMRF)*		Home Office Allocation	553	
				Employee Relations	3,951	Miscellaneous Licenses & Permits	279	
						LTC Solutions License	1,600	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 39,215			IHCA Dues	2,043	
B. Administrative - Other						Less: Public Relations Expense	(150)	
Description			Amount			Non-allowable advertising	()	
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 50,000			Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 50,000	TOTAL (agree to Schedule V, line 22, col.8)	\$ 210,954	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 6,042	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
E-Health Data Solutions	Computer Services		\$ 2,025				Out-of-State Travel	\$
McGladrey & Pullen, LLC	Accounting Services		6,080					
Hamilton Co. Communications	Computer Services		322	N/A			In-State Travel	
							Seminar Expense	65
							Home Office Allocation	362
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 8,427	TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)	\$ 427

* Attach copy of IMRF notifications

**See instructions.

McLeansboro Rehabilitation & Health Care Center

0047498

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 Sch. V, line 19, col.3)		8,427
Home Office Allocations		
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 & Company	Accountants	1,734
RSM McGladrey	Accountants	93
McGladrey & Pullen	Accountants	142
Emdeon Business Services	Computer Services	37
Advance Answers on Demand	Computer Services	999
Access 2 Go	Computer Services	75
Ivans	Computer Services	335
Kemper Technology	Computer Services	157
Administar Federal	Computer Services	19
Logmein	Computer Services	12
E-Health Data Solutions	Computer Services	98
Miscellaneous Vendors	Computer Services	12
Julie Breedlove	Computer Services	12
Amerisearch	Employment Fees	453
Total (agree to Schedule V, line 19, column 8)		<u>12,716</u>

Facility Name & ID Number McLeansboro Rehabilitation & Health Care Center# 0047498Report 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. \$ 3,753 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. \$ 23,543
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,145
- (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