

Facility Name & ID Number Orchard View Rehab & Health Care

0049007 Report Period Beginning: 07/01/2007 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	75	Skilled (SNF)	75	13,800	1
2		Skilled Pediatric (SNF/PED)			2
3	48	Intermediate (ICF)	48	8,832	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	123	TOTALS	123	22,632	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			741	741	8
9	SNF/PED					9
10	ICF	9,040	1,724		10,764	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,040	1,724	741	11,505	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 50.84%

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)

Jail Meals

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 7/1/2007

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

YES

Date 7/1/2007

NO

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

YES

NO

If YES, enter number of beds certified 48 and days of care provided 741

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL

MODIFIED

CASH*

CASH*

Is your fiscal year identical to your tax year?

YES NO

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

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

Facility Name & ID Number Orchard View Rehab & Health Care # 0049007 Report Period Beginning: 07/01/2007 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	93,260	9,594	2,199	105,053		105,053	963	106,016		1
2	Food Purchase		70,248		70,248		70,248	(40,249)	29,999		2
3	Housekeeping	48,814	14,248		63,062		63,062	15	63,077		3
4	Laundry	29,013	6,789		35,802		35,802	1	35,803		4
5	Heat and Other Utilities			43,988	43,988		43,988	164	44,152		5
6	Maintenance	35,273	9,152	15,511	59,936		59,936	1,408	61,344		6
7	Other (specify):* <u>Home Off. Ben. All.</u>							439	439		7
8	TOTAL General Services	206,360	110,031	61,698	378,089		378,089	(37,259)	340,830		8
	B. Health Care and Programs										
9	Medical Director			7,200	7,200		7,200		7,200		9
10	Nursing and Medical Records	523,327	30,391	129,599	683,317		683,317	2,558	685,875		10
10a	Therapy			67,415	67,415		67,415		67,415		10a
11	Activities	27,119	1,035	77	28,231		28,231		28,231		11
12	Social Services	21,705			21,705		21,705		21,705		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Off. Ben. All.</u>							566	566		15
16	TOTAL Health Care and Programs	572,151	31,426	204,291	807,868		807,868	3,124	810,992		16
	C. General Administration										
17	Administrative	25,042			25,042		25,042	7,167	32,209		17
18	Directors Fees										18
19	Professional Services			2,907	2,907		2,907	2,625	5,532		19
20	Dues, Fees, Subscriptions & Promotions			5,594	5,594		5,594	332	5,926		20
21	Clerical & General Office Expenses	20,749	1,621	4,125	26,495		26,495	17,681	44,176		21
22	Employee Benefits & Payroll Taxes			86,790	86,790		86,790		86,790		22
23	Inservice Training & Education			600	600		600	207	807		23
24	Travel and Seminar							299	299		24
25	Other Admin. Staff Transportation			5,265	5,265		5,265	1,146	6,411		25
26	Insurance-Prop.Liab.Malpractice			8,574	8,574		8,574	510	9,084		26
27	Other (specify):* <u>Home Off. Ben. All.</u>							4,666	4,666		27
28	TOTAL General Administration	45,791	1,621	113,855	161,267		161,267	34,633	195,900		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	824,302	143,078	379,844	1,347,224		1,347,224	498	1,347,722		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

Orchard View Rehab & Health Care

#0049007

Report Period Beginning:

07/01/2007

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			42,341	42,341		42,341	(8,344)	33,997			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			48,934	48,934		48,934	4,174	53,108			32
33	Real Estate Taxes			40,000	40,000		40,000	377	40,377			33
34	Rent-Facility & Grounds							23	23			34
35	Rent-Equipment & Vehicles			3,292	3,292		3,292	303	3,595			35
36	Other (specify):*											36
37	TOTAL Ownership			134,567	134,567		134,567	(3,467)	131,100			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		20,685		20,685		20,685		20,685			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			33,948	33,948		33,948		33,948			42
43	Other (specify):* Non-allowable Cost	16,513	194	45,794	62,501		62,501	(62,501)				43
44	TOTAL Special Cost Centers	16,513	20,879	79,742	117,134		117,134	(62,501)	54,633			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	840,815	163,957	594,153	1,598,925		1,598,925	(65,470)	1,533,455			45

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

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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,577)	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	(9,676)	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	(187)	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	(200)	43		18
19	Entertainment				19
20	Contributions	(151)	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	(32,040)	43		24
25	Fund Raising, Advertising and Promotional	(28,133)	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	(38,690)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (112,654)		\$	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)	47,184	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 47,184		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (65,470)		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

Orchard View Rehab & Health Care

ID# 0049007

Report Period Beginning: 07/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (1,198)	43	1
2	X-Rays-Part A	(592)	43	2
3	Offset Jail Meal Revenue	(36,705)	2	3
4	Offset Miscellaneous Office Supplies Revenue	(105)	21	4
5	Offset Chamber of Commerce Dues	(90)	20	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	(38,690)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Orchard View Rehab & Health Care

0049007

Report Period Beginning:

07/01/2007

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	963	0	0	0	0	0	0	0	0	0	963	1
2	Food Purchase	(40,282)	33	0	0	0	0	0	0	0	0	0	(40,249)	2
3	Housekeeping	0	11	0	4	0	0	0	0	0	0	0	15	3
4	Laundry	0	1	0	0	0	0	0	0	0	0	0	1	4
5	Heat and Other Utilities	0	164	0	0	0	0	0	0	0	0	0	164	5
6	Maintenance	0	1,341	0	67	0	0	0	0	0	0	0	1,408	6
7	Other (specify):*	0	439	0	0	0	0	0	0	0	0	0	439	7
8	TOTAL General Services	(40,282)	2,952	0	71	0	(37,259)	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	2,546	0	12	0	0	0	0	0	0	0	2,558	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	566	0	0	0	0	0	0	0	0	0	566	15
16	TOTAL Health Care and Programs	0	3,112	0	12	0	3,124	16						
	C. General Administration													
17	Administrative	0	7,167	0	0	0	0	0	0	0	0	0	7,167	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	1,946	0	679	0	0	0	0	0	0	0	2,625	19
20	Fees, Subscriptions & Promotions	(90)	0	422	0	0	0	0	0	0	0	0	332	20
21	Clerical & General Office Expenses	(105)	0	16,319	1,467	0	0	0	0	0	0	0	17,681	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	188	19	0	0	0	0	0	0	0	207	23
24	Travel and Seminar	0	0	299	0	0	0	0	0	0	0	0	299	24
25	Other Admin. Staff Transportation	0	0	1,082	64	0	0	0	0	0	0	0	1,146	25
26	Insurance-Prop.Liab.Malpractice	0	0	441	69	0	0	0	0	0	0	0	510	26
27	Other (specify):*	0	0	4,666	0	0	0	0	0	0	0	0	4,666	27
28	TOTAL General Administration	(195)	9,113	23,417	2,298	0	34,633	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(40,477)	15,177	23,417	2,381	0	498	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Orchard View Rehab & Health Care# 0049007

Report Period Beginning:

07/01/2007

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	(9,676)	0	1,143	189	0	0	0	0	0	0	0	(8,344)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	1,986	2,188	0	0	0	0	0	0	0	4,174	32
33	Real Estate Taxes	0	0	377	0	0	0	0	0	0	0	0	377	33
34	Rent-Facility & Grounds	0	0	23	0	0	0	0	0	0	0	0	23	34
35	Rent-Equipment & Vehicles	0	0	303	0	0	0	0	0	0	0	0	303	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(9,676)	0	3,832	2,377	0	(3,467)	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):*	(62,501)	0	0	0	0	0	0	0	0	0	0	(62,501)	43
44	TOTAL Special Cost Centers	(62,501)	0	0	0	0	0	0	0	0	0	0	(62,501)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(112,654)	15,177	27,249	4,758	0	(65,470)	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%	\$ 963	\$ 963	1	
2	V	2 Food		Petersen Health Care, Inc.	100.00%	33	33	2	
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	11	11	3	
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	1	1	4	
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	164	164	5	
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	1,341	1,341	6	
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	439	439	7	
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	2,546	2,546	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%	566	566	10	
11	V	17 Administrative		Petersen Health Care, Inc.	100.00%	7,167	7,167	11	
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	1,946	1,946	12	
13	V							13	
14	Total		\$			\$ 15,177	\$ *	15,177	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%	\$ 422	\$ 422	15
16	V	21	Clerical and General Office		Petersen Health Care, Inc.	100.00%	16,319	16,319	16
17	V	23	Inservice Training and Education		Petersen Health Care, Inc.	100.00%	188	188	17
18	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	299	299	18
19	V	25	Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	1,082	1,082	19
20	V	26	Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	441	441	20
21	V	27	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	4,666	4,666	21
22	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	1,143	1,143	22
23	V	32	Interest		Petersen Health Care, Inc.	100.00%	1,986	1,986	23
24	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	377	377	24
25	V	34	Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	23	23	25
26	V	35	Rent-Equipment and Vehicles		Petersen Health Care, Inc.	100.00%	303	303	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		\$				\$ 27,249	\$ * 27,249	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1 <u>Dietary</u>	\$	<u>Petersen Companies, LLC</u>	100.00%	\$ 0	\$	0	15
16	V	2 <u>Food</u>		<u>Petersen Companies, LLC</u>	100.00%	0		0	16
17	V	3 <u>Housekeeping</u>		<u>Petersen Companies, LLC</u>	100.00%	4		4	17
18	V	4 <u>Laundry</u>		<u>Petersen Companies, LLC</u>	100.00%	0		0	18
19	V	5 <u>Utilities</u>		<u>Petersen Companies, LLC</u>	100.00%	0		0	19
20	V	6 <u>Maintenance</u>		<u>Petersen Companies, LLC</u>	100.00%	67		67	20
21	V	7 <u>Mgmt. Allocation of Benefits</u>		<u>Petersen Companies, LLC</u>	100.00%	0		0	21
22	V	10 <u>Nursing and Medical Records</u>		<u>Petersen Companies, LLC</u>	100.00%	12		12	22
23	V	10A <u>Therapy</u>		<u>Petersen Companies, LLC</u>	100.00%	0		0	23
24	V	15 <u>Mgmt. Allocation of Benefits</u>		<u>Petersen Companies, LLC</u>	100.00%	0		0	24
25	V	17 <u>Administrative</u>		<u>Petersen Companies, LLC</u>	100.00%	0		0	25
26	V	19 <u>Professional Services</u>		<u>Petersen Companies, LLC</u>	100.00%	679		679	26
27	V	20 <u>Dues, Fees, Subs and Promotions</u>		<u>Petersen Companies, LLC</u>	100.00%	0		0	27
28	V	21 <u>Clerical and General Office</u>		<u>Petersen Companies, LLC</u>	100.00%	1,467		1,467	28
29	V	23 <u>Inservice Training and Education</u>		<u>Petersen Companies, LLC</u>	100.00%	19		19	29
30	V	24 <u>Travel and Seminar</u>		<u>Petersen Companies, LLC</u>	100.00%	0		0	30
31	V	25 <u>Other Admin. Staff Transportation</u>		<u>Petersen Companies, LLC</u>	100.00%	64		64	31
32	V	26 <u>Insurance-Prop./Liab/Malpractice</u>		<u>Petersen Companies, LLC</u>	100.00%	69		69	32
33	V	27 <u>Mgmt. Allocation of Benefits</u>		<u>Petersen Companies, LLC</u>	100.00%	0		0	33
34	V	30 <u>Depreciation</u>		<u>Petersen Companies, LLC</u>	100.00%	189		189	34
35	V	32 <u>Interest</u>		<u>Petersen Companies, LLC</u>	100.00%	2,188		2,188	35
36	V	33 <u>Real Estate Taxes</u>		<u>Petersen Companies, LLC</u>	100.00%	0		0	36
37	V	34 <u>Rent-Facility and Grounds</u>		<u>Petersen Companies, LLC</u>	100.00%	0		0	37
38	V	35 <u>Rent-Equipment and Vehicles</u>		<u>Petersen Companies, LLC</u>	100.00%	0		0	38
39	Total		\$			\$ 4,758	\$ *	4,758	39

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

Facility Name & ID Number Orchard View Rehab & Health Care # 0049007 Report Period Beginning: 07/01/2007 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	0.47	0.86	Salary	\$ 7,167	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	\$ 7,167		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 Orchard View Rehab & Health Care# 0049007

Report Period Beginning:

07/01/2007Ending: 2/31/2007

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization

Petersen Health Care, Inc.

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309) 691-8113

Fax Number

(309) 691-8622

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,316,550	66	\$ 110,171	\$ 109,587	11,505	\$ 963	1
2	2	Food	Resident Days	1,316,550	66	3,806	0	11,505	33	2
3	3	Housekeeping	Resident Days	1,316,550	66	1,250	0	11,505	11	3
4	4	Laundry	Resident Days	1,316,550	66	73	0	11,505	1	4
5	5	Utilities	Resident Days	1,316,550	66	18,812	0	11,505	164	5
6	6	Maintenance	Resident Days	1,316,550	66	153,468	113,063	11,505	1,341	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	50,271	0	11,505	439	7
8	10	Nursing and Medical Records	Resident Days	1,316,550	66	291,305	286,855	11,505	2,546	8
9	10A	Therapy	Resident Days	1,316,550	66	0	0	11,505	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	64,765	0	11,505	566	10
11	17	Administrative	Resident Days	1,316,550	66	820,116	820,116	11,505	7,167	11
12	19	Professional Services	Resident Days	1,316,550	66	222,628	0	11,505	1,946	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,316,550	66	48,243	0	11,505	422	13
14	21	Clerical and General Office	Resident Days	1,316,550	66	1,867,440	1,544,801	11,505	16,319	14
15	23	Inservice Training & Education	Resident Days	1,316,550	66	21,481	0	11,505	188	15
16	24	Travel and Seminar	Resident Days	1,316,550	66	34,177	0	11,505	299	16
17	25	Other Admin. Staff Transport.	Resident Days	1,316,550	66	123,847	0	11,505	1,082	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,316,550	66	50,427	0	11,505	441	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	533,953	0	11,505	4,666	19
20	30	Depreciation	Resident Days	1,316,550	66	130,767	0	11,505	1,143	20
21	32	Interest	Resident Days	1,316,550	66	227,295	0	11,505	1,986	21
22	33	Real Estate Taxes	Resident Days	1,316,550	66	43,090	0	11,505	377	22
23	34	Rent-Facility and Grounds	Resident Days	1,316,550	66	2,648	0	11,505	23	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,316,550	66	34,690	0	11,505	303	24
25	TOTALS					\$ 4,854,723	\$ 2,874,422		\$ 42,426	25

Facility Name & ID Number Orchard View Rehab & Health Care# 0049007

Report Period Beginning:

07/01/2007Ending: 2/31/2007

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization

Petersen Companies, LLC

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309) 691-8113

Fax Number

(309) 691-8622

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	179,368	12	\$	11,505	\$	1
2	2	Food	Resident Days	179,368	12		11,505		2
3	3	Housekeeping	Resident Days	179,368	12	70	11,505	4	3
4	4	Laundry	Resident Days	179,368	12		11,505		4
5	5	Utilities	Resident Days	179,368	12		11,505		5
6	6	Maintenance	Resident Days	179,368	12	1,038	11,505	67	6
7	7	Mgmt. Allocation of Benefits	Resident Days	179,368	12		11,505		7
8	10	Nursing and Medical Records	Resident Days	179,368	12	189	11,505	12	8
9	10A	Therapy	Resident Days	179,368	12		11,505		9
10	15	Mgmt. Allocation of Benefits	Resident Days	179,368	12		11,505		10
11	17	Administrative	Resident Days	179,368	12		11,505		11
12	19	Professional Services	Resident Days	179,368	12	10,592	11,505	679	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	179,368	12		11,505		13
14	21	Clerical and General Office	Resident Days	179,368	12	22,877	11,505	1,467	14
15	23	Inservice Training & Education	Resident Days	179,368	12	300	11,505	19	15
16	24	Travel and Seminar	Resident Days	179,368	12		11,505		16
17	25	Other Admin. Staff Transport.	Resident Days	179,368	12	993	11,505	64	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	179,368	12	1,070	11,505	69	18
19	27	Mgmt. Allocation of Benefits	Resident Days	179,368	12		11,505		19
20	30	Depreciation	Resident Days	179,368	12	2,941	11,505	189	20
21	32	Interest	Resident Days	179,368	12	34,114	11,505	2,188	21
22	33	Real Estate Taxes	Resident Days	179,368	12		11,505		22
23	34	Rent-Facility and Grounds	Resident Days	179,368	12		11,505		23
24	35	Rent-Equipment & Vehicles	Resident Days	179,368	12		11,505		24
25	TOTALS					\$ 74,184	\$	\$ 4,758	25

Facility Name & ID Number

Orchard View Rehab & Health Care

0049007

Report Period Beginning:

07/01/2007

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	Citizens First National Bank		X	Mortgage	\$13,346.04	06/29/07	\$ 1,400,000	\$ 1,379,426	07/05/12	Varies	\$ 46,357	1					
2												2					
3							Amortization Expense				2,577	3					
4							Home Office Allocation				4,174	4					
5												5					
Working Capital																	
6												6					
7												7					
8												8					
9	TOTAL Facility Related				\$13,346.04		\$ 1,400,000	\$ 1,379,426			\$ 53,108	9					
B. Non-Facility Related*																	
10												10					
11												11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$	14					
15	TOTALS (line 9+line14)						\$ 1,400,000	\$ 1,379,426			\$ 53,108	15					

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

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2006 report.		\$	1	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2006	\$	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	3	
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	40,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. Home Office Allocation			377	
TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	40,377	7

Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2002	_____	8
	2003	_____	9
	2004	_____	10
	2005	_____	11
	2006	_____	12

Accrual based on estimate of assessed value times the tax rate			
	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2006	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2007 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Orchard View Rehab & Health Care COUNTY Bureau

FACILITY IDPH LICENSE NUMBER 0049007

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

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: 51,745 B. General Construction Type: Exterior Concrete Brick Frame Block Number of Stories 3

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>51,745</u>	<u>2007</u>	<u>\$ 55,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	51,745		\$ 55,000	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	123	2007	1961	\$ 1,120,000	\$	30	\$ 18,667	\$ 18,667	\$ 18,667	4
5										5
6										6
7	Home Office Allocation			6,414			157	157		7
8										8
Improvement Type**										
9	Original Land Improvements		2007	15,000		15	500	500	500	9
10	Fire Alarm		2007	2,148		15	72	72	72	10
11	Exterior Sign		2007	1,749		15	58	58	58	11
12	Plumbing-Kitchen		2007	4,300		15	143	143	143	12
13										13
14										14
15										15
16										16
17										17
18										18
19	Building Booked				24,267			(24,267)		19
20	Land Improvements Booked				1,071			(1,071)		20
21	Building Improvements Booked				186			(186)		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			429			25	25		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)	\$ 1,150,040	\$ 25,524		\$ 19,622	\$ (5,902)	\$ 19,440	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	\$	\$	\$	\$		\$	71
72	Current Year Purchases	210,000	15,000	10,500	(4,500)	10	10,500	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			1,150	1,150			74
75	TOTALS	\$ 210,000	\$ 15,000	\$ 11,650	\$ (3,350)		\$ 10,500	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	Facility	2007 Ford E-150	2007	\$ 27,248	\$ 1,817	\$ 2,725	\$ 908	5	\$ 2,725	76
77										77
78										78
79										79
80	TOTALS			\$ 27,248	\$ 1,817	\$ 2,725	\$ 908		\$ 2,725	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)	\$ 1,442,288	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 42,341	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 33,997	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (8,344)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 32,665	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6		<u>Home Office Allocation</u>			<u>23</u>			6
7	TOTAL				\$ <u>23</u>			7

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 3,595 Description: See Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /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.

Orchard View Rehab & Health Care
0049007

Period Beginning 07/01/2007

Period End 12/31/2007

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Copier	\$ 3,000
Medical Equipment	292
Home Office Allocation	303
	<u>3,595</u>

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L. 10A, C. 3	hrs	\$	1,655	\$ 24,819	\$	1,655	\$ 24,819	1
2	Licensed Speech and Language Development Therapist	L. 10A ,C. 3	hrs		54	814		54	814	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L. 10A, C. 3	hrs		2,785	41,782		2,785	41,782	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L. 39, C. 2	# of prescripts				20,685		20,685	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			\$	4,494	\$ 67,415	\$ 20,685	4,494	\$ 88,100	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 Orchard View Rehab & Health Care

0049007

Report Period Beginning: 07/01/2007

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	\$ (265,393)	\$ (265,393)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>N/A</u>)	382,811	382,811	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	13,877	13,877	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): _____			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 131,295	\$ 131,295	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		55,000	13
14	Buildings, at Historical Cost	1,190,000	1,126,843	14
15	Leasehold Improvements, at Historical Cost	8,197	23,197	15
16	Equipment, at Historical Cost	237,248	237,248	16
17	Accumulated Depreciation (book methods)	(42,341)	(32,665)	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 (spec <u>Loan costs</u>)	9,450	9,450	22
23	Other(specify): _____			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,402,554	\$ 1,419,073	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,533,849	\$ 1,550,368	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 286,444	\$ 286,444	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	54,891	54,891	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,106	7,106	31
32	Accrued Real Estate Taxes(Sch.IX-B)	40,000	40,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	28,966	28,966	36
37	_____			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 417,407	\$ 417,407	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,379,426	1,379,426	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Due to Prior Owner</u>	9,406	9,406	43
44	_____			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,388,832	\$ 1,388,832	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,806,239	\$ 1,806,239	46
47	TOTAL EQUITY (page 18, line 24)	\$ (272,390)	\$ (255,871)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,533,849	\$ 1,550,368	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(272,390)	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)	\$ (272,390)	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)	\$ (272,390)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Orchard View Rehab & Health Care

0049007

Report Period Beginning: 07/01/2007

Ending: 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	\$ 1,112,877	1
2	Discounts and Allowances for all Levels	37,570	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,150,447	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	97,628	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 97,628	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	3,577	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	34,838	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	2,417	20
21	Other Medical Services	808	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 41,640	23
	D. Non-Operating Revenue		
24	Contributions	10	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 10	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	<u>Miscellaneous Revenue-See Sch. 19A</u>	36,810	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 36,810	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,326,535	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	378,089	31
32	Health Care	807,868	32
33	General Administration	161,267	33
	B. Capital Expense		
34	Ownership	134,567	34
	C. Ancillary Expense		
35	Special Cost Centers	83,186	35
36	Provider Participation Fee	33,948	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,598,925	40
41	Income before Income Taxes (line 30 minus line 40)**	(272,390)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (272,390)	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.

Orchard View Rehab & Health Care
0049007
Period Beginning 07/01/2007
Period End 12/31/2007

Schedule 19A

XVII. INCOME STATEMENT

Line 28a - Other revenue	
Meals on Wheels	36,705
Office Supplies	<u>105</u>
	<u>36,810</u>

Facility Name & ID Number Orchard View Rehab & Health Care

0049007

Report Period Beginning: 07/01/2007

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	993	1,001	\$ 23,704	\$ 23.68	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,568	2,568	56,156	21.87	3
4	Licensed Practical Nurses	5,866	5,866	110,662	18.86	4
5	CNAs & Orderlies	27,095	27,095	298,388	11.01	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,040	1,040	12,814	12.32	9
10	Activity Assistants	1,834	1,834	14,305	7.80	10
11	Social Service Workers	1,967	1,967	21,705	11.03	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	29,598	14.23	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,373	7,373	63,662	8.63	15
16	Dishwashers					16
17	Maintenance Workers	2,929	2,929	35,273	12.04	17
18	Housekeepers	5,534	5,534	48,814	8.82	18
19	Laundry	3,288	3,288	29,013	8.82	19
20	Administrator	1,040	1,040	25,042	24.08	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,091	2,097	20,749	9.89	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	1,020	1,020	10,070	9.87	31
32	Other Health C: Care Plan Coord	1,072	1,072	24,347	22.71	32
33	Other(specify) <u>Marketing</u>	1,032	1,032	16,513	16.00	33
34	TOTAL (lines 1 - 33)	68,822	68,836	\$ 840,815 *	\$ 12.21	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	Monthly	\$ 2,199	L. 1, C. 3	35
36	Medical Director	Monthly	7,200	L. 9, C. 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	600	L. 10, C. 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 9,999		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	3,152	128,999	L. 10, C. 3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	3,152	\$ 128,999		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>Lori Walsh</u>	<u>Administrator</u>	<u>0</u>	\$ <u>25,042</u>	<u>Workers' Compensation Insurance</u>	\$ <u>0</u>	<u>IDPH License Fee</u>	\$ <u>995</u>	
				<u>Unemployment Compensation Insurance</u>	<u>19,237</u>	<u>Advertising: Employee Recruitment</u>	<u>302</u>	
				<u>FICA Taxes</u>	<u>57,758</u>	<u>Health Care Worker Background Check</u>	<u>398</u>	
				<u>Employee Health Insurance</u>	<u>(1,976)</u>	<u>(Indicate # of checks performed <u>40</u>)</u>		
				<u>Employee Meals</u>				
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>LTC Solutions License</u>	<u>1,930</u>	
						<u>Miscellaneous Dues & Licenses</u>	<u>1,969</u>	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ <u>25,042</u>	<u>Employee Retirement</u>	<u>72</u>	<u>Home Office Allocation</u>	<u>422</u>	
(List each licensed administrator separately.)				<u>Employee Relations</u>	<u>11,699</u>			
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			\$ <u>86,790</u>	
Description			Amount	G. Schedule of Travel and Seminar**				
<u>Management Fees-See Page 6, Eliminated on P 3, C 7</u>			\$ <u>0</u>	Description		Amount		
				<u>Out-of-State Travel</u>		\$		
				<u>In-State Travel</u>				
TOTAL (agree to Schedule V, line 17, col. 3)			\$	<u>Seminar Expense</u>				
(Attach a copy of any management service agreement)				<u>Home Office Allocation</u>		<u>299</u>		
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		<u>Entertainment Expense</u>		
Vendor/Payee		Type	Amount	Description	Line #	(agree to Sch. V, line 24, col. 8)		
<u>Brown & James</u>	<u>Legal</u>		\$ <u>416</u>			\$ <u>299</u>		
<u>Network Business Systems</u>	<u>Computer Services</u>		<u>280</u>	<u>N/A</u>				
<u>Omnicare</u>	<u>Computer Services</u>		<u>1,290</u>					
<u>IVANS</u>	<u>Computer Services</u>		<u>246</u>					
<u>E-Health Data Solutions</u>	<u>Computer Services</u>		<u>675</u>					
TOTAL (agree to Schedule V, line 19, column 3)			\$ <u>2,907</u>	TOTAL		\$		
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications

**See instructions.

Orchard View Rehab & Health Care

0049007

Period Beginning 07/01/2007

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)		2,907
--	--	-------

Non-allowable legal expense

Home Office Allocation

Petersen Health Care, Inc

Pearl & Associates	Legal	13
Addy Bush & Assoc	Legal	6
Registered Agent Solutions	Legal	1
Heyl, Royster, Voelker & Allen	Legal	28
Duane Morris	Legal	44
Ginoli & Co.	Accountants	445
RSM McGladrey	Accountants	77
McGladrey & Pullen	Accountants	117
Emdeon Business Services	Computer Services	31
Advanced Answers on Demand	Computer Services	825
Access 2 Go	Computer Services	62
Ivans	Computer Services	55
Kemper Technology	Computer Services	129
Adminastar Federal	Computer Services	16
Logmein	Computer Services	10
E-Health Data Solutions	Computer Services	81
Miscellaneous Vendors	Miscellaneous	6

Petersen Companies, LLC

Miscellaneous Vendors	Legal	32
Ginoli & Co.	Accountants	272
McGladrey & Pullen	Accountants	375

Non-allowable Legal

Total (agree to Schedule V, line 19, column 8)		<u><u>5,532</u></u>
--	--	---------------------

Facility Name & ID Number Orchard View Rehab & Health Care

0049007

Report Period Beginning: 07/01/2007

Ending: 12/31/2007

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 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. \$ 33,948
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. \$ 40,282
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees