

Facility Name & ID Number Bloomington Rehabilitation & Health Care Center

0047415 Report Period Beginning: 1/1/2008 Ending: 12/31/2008

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	26	Skilled (SNF)	26	9,516	1
2		Skilled Pediatric (SNF/PED)			2
3	52	Intermediate (ICF)	52	19,032	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	78	TOTALS	78	28,548	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			1,254	1,254	8
9	SNF/PED					9
10	ICF	12,193	1,230		13,423	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,193	1,230	1,254	14,677	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 51.41%

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 10/01/05

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

YES

Date 10/01/05

NO

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

YES

NO

If YES, enter number of beds certified 26 and days of care provided 1,254

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: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number Bloomington Rehabilitation & Health Care C # 0047415 Report Period Beginning: 1/1/2008 Ending: 12/31/2008

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	103,768	9,376		113,144		113,144	2,609	115,753		1
2	Food Purchase		84,151		84,151		84,151	(2,173)	81,978		2
3	Housekeeping	55,144	22,004		77,148		77,148	19	77,167		3
4	Laundry	28,482	13,140		41,622		41,622	1	41,623		4
5	Heat and Other Utilities			65,146	65,146		65,146	270	65,416		5
6	Maintenance	49,935	25,303	25,871	101,109		101,109	2,395	103,504		6
7	Other (specify):* <u>Home Off. Ben. All.</u>							888	888		7
8	TOTAL General Services	237,329	153,974	91,017	482,320		482,320	4,009	486,329		8
	B. Health Care and Programs										
9	Medical Director			17,250	17,250		17,250		17,250		9
10	Nursing and Medical Records	681,441	45,129	25,093	751,663		751,663	3,572	755,235		10
10a	Therapy		229	225,395	225,624		225,624		225,624		10a
11	Activities	26,180	518	42	26,740		26,740	(622)	26,118		11
12	Social Services	7,879			7,879		7,879	7	7,886		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Off. Ben. All.</u>							791	791		15
16	TOTAL Health Care and Programs	715,500	45,876	267,780	1,029,156		1,029,156	3,748	1,032,904		16
	C. General Administration										
17	Administrative	62,128		103,000	165,128		165,128	(81,098)	84,030		17
18	Directors Fees										18
19	Professional Services			4,860	4,860		4,860	4,347	9,207		19
20	Dues, Fees, Subscriptions & Promotions			9,606	9,606		9,606	289	9,895		20
21	Clerical & General Office Expenses	33,030	7,057	9,284	49,371		49,371	29,258	78,629		21
22	Employee Benefits & Payroll Taxes			287,536	287,536		287,536		287,536		22
23	Inservice Training & Education			350	350		350	165	515		23
24	Travel and Seminar							165	165		24
25	Other Admin. Staff Transportation			5,671	5,671		5,671	5,715	11,386		25
26	Insurance-Prop.Liab.Malpractice			15,214	15,214		15,214	122	15,336		26
27	Other (specify):* <u>Home Off. Ben. All.</u>							8,382	8,382		27
28	TOTAL General Administration	95,158	7,057	435,521	537,736		537,736	(32,655)	505,081		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,047,987	206,907	794,318	2,049,212		2,049,212	(24,898)	2,024,314		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

Bloomington Rehabilitation & Health Care Center

#0047415

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

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			40,207	40,207		40,207	3,735	43,942			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			35,691	35,691		35,691	9,272	44,963			32
33	Real Estate Taxes			28,721	28,721		28,721	372	29,093			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			26,449	26,449		26,449	318	26,767			35
36	Other (specify):*											36
37	TOTAL Ownership			131,068	131,068		131,068	13,697	144,765			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		28,984		28,984		28,984		28,984			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			42,822	42,822		42,822		42,822			42
43	Other (specify):* Non-allowable Cost	25,177	1,385	115,141	141,703		141,703	(141,703)				43
44	TOTAL Special Cost Centers	25,177	30,369	157,963	213,509		213,509	(141,703)	71,806			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,073,164	237,276	1,083,349	2,393,789		2,393,789	(152,904)	2,240,885			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(5,245)	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	47	30		9
10	Interest and Other Investment Income	(117)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(138)	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	(2,887)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(84,388)	43		24
25	Fund Raising, Advertising and Promotional	(46,977)	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	(6,486)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (146,191)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	(6,713)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (6,713)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (152,904)		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Bloomington Rehabilitation & Health Care Center

ID# 0047415

Report Period Beginning: 1/1/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (1,101)	43	1
2	X-Rays-Part A	(1,079)	43	2
3	Offset Miscellaneous Nursing Supplies Revenue	(956)	10	3
4	Offset Miscellaneous Food Revenue	(2,218)	2	4
5	Offset Miscellaneous Office Supplies Revenue	(169)	21	5
6	Offset Chamber of Commerce Dues	(453)	20	6
7	Offset Transportation Activity Revenue	(438)	11	7
8	Offset Transportation Trans. Revenue	(184)	11	8
9	Disallowed Special Events	112	43	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
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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	(6,486)		49

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 2,609	\$ 2,609	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	43	43	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	19	19	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	1	1	4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	270	270	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	1,594	1,594	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	641	641	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	4,528	4,528	8
9	V	11 Activities		Petersen Health Care, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	791	791	10
11	V	17 Administrative	103,000	Petersen Health Care, Inc.	100.00%	20,309	(82,691)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	2,292	2,292	12
13	V							13
14	Total		\$ 103,000			\$ 33,097	\$ * (69,903)	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%	\$ 707	\$	707	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	25,485		25,485	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	155		155	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	155		155	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	2,007		2,007	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	122		122	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	7,256		7,256	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	2,777		2,777	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	1,953		1,953	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	372		372	24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0			25
26	V	35 Rent-Equipment and Vehicles		Petersen Health Care, Inc.	100.00%	318		318	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		\$			\$ 41,307	\$ *	41,307	39

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

Facility Name & ID Number Bloomington Rehabilitation & Health Care Center# 0047415Report Period Beginning: 1/1/2008Ending: 12/31/2008

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%	\$ 0	\$	15	
16	V	2 Food		Petersen Health Operations, LLC	100.00%	2	2	16	
17	V	3 Housekeeping		Petersen Health Operations, LLC	100.00%	0		17	
18	V	4 Laundry		Petersen Health Operations, LLC	100.00%	0		18	
19	V	5 Utilities		Petersen Health Operations, LLC	100.00%	0		19	
20	V	6 Maintenance		Petersen Health Operations, LLC	100.00%	801	801	20	
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	247	247	21	
22	V	10 Nursing and Medical Records		Petersen Health Operations, LLC	100.00%	0		22	
23	V	12 Social Services		Petersen Health Operations, LLC	100.00%	7	7	23	
24	V	17 Administrative		Petersen Health Operations, LLC	100.00%	1,593	1,593	24	
25	V	19 Professional Services		Petersen Health Operations, LLC	100.00%	2,055	2,055	25	
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Operations, LLC	100.00%	35	35	26	
27	V	21 Clerical and General Office		Petersen Health Operations, LLC	100.00%	3,942	3,942	27	
28	V	22 Employee Benefits & Payroll		Petersen Health Operations, LLC	100.00%	0		28	
29	V	23 Inservice Training & Education		Petersen Health Operations, LLC	100.00%	10	10	29	
30	V	24 Travel and Seminar		Petersen Health Operations, LLC	100.00%	10	10	30	
31	V	25 Other Admin. Staff Transport.		Petersen Health Operations, LLC	100.00%	3,708	3,708	31	
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Operations, LLC	100.00%	0		32	
33	V	27 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	1,126	1,126	33	
34	V	30 Depreciation		Petersen Health Operations, LLC	100.00%	911	911	34	
35	V	32 Interest		Petersen Health Operations, LLC	100.00%	7,436	7,436	35	
36	V	33 Real Estate Taxes		Petersen Health Operations, LLC	100.00%	0		36	
37	V	34 Rent-Facility and Grounds		Petersen Health Operations, LLC	100.00%	0		37	
38	V	35 Rent-Equipment & Vehicles		Petersen Health Operations, LLC	100.00%	0		38	
39	Total		\$			\$ 21,883	\$ *	21,883	39

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

Facility Name & ID Number Bloomington Rehabilitation & Health Care (# 0047415 Report Period Beginning: 1/1/2008 Ending: 12/31/2008

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	1,808,365	0.61	1.02	Salary	20,309	L17, C7	1
2											2
3											3
4	***Other Nursing Home Compensation and Compensation are										4
5	Attached on Schedule 7A										5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 20,309		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 Bloomington Rehabilitation & Health Care Center # 0047415 Report Period Beginning: 1/1/2008 Ending: 2/31/2008

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	1,413,604	69	\$ 251,260	\$ 250,687	14,677	\$ 2,609	1
2	2	Food	Resident Days	1,413,604	69	4,125	0	14,677	43	2
3	3	Housekeeping	Resident Days	1,413,604	69	1,859	0	14,677	19	3
4	4	Laundry	Resident Days	1,413,604	69	110	0	14,677	1	4
5	5	Utilities	Resident Days	1,413,604	69	26,036	0	14,677	270	5
6	6	Maintenance	Resident Days	1,413,604	69	153,551	100,245	14,677	1,594	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	61,774	0	14,677	641	7
8	10	Nursing and Medical Records	Resident Days	1,413,604	69	436,084	432,530	14,677	4,528	8
9	10A	Therapy	Resident Days	1,413,604	69	0	0	14,677	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	76,136	0	14,677	791	10
11	17	Administrative	Resident Days	1,413,604	69	1,955,999	1,956,000	14,677	20,309	11
12	19	Professional Services	Resident Days	1,413,604	69	220,762	0	14,677	2,292	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,413,604	69	68,094	0	14,677	707	13
14	21	Clerical and General Office	Resident Days	1,413,604	69	2,454,596	2,013,896	14,677	25,485	14
15	23	Inservice Training & Education	Resident Days	1,413,604	69	14,912	0	14,677	155	15
16	24	Travel and Seminar	Resident Days	1,413,604	69	14,938	0	14,677	155	16
17	25	Other Admin. Staff Transport.	Resident Days	1,413,604	69	193,264	0	14,677	2,007	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,413,604	69	11,767	0	14,677	122	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	698,810	0	14,677	7,256	19
20	30	Depreciation	Resident Days	1,413,604	69	267,426	0	14,677	2,777	20
21	32	Interest	Resident Days	1,413,604	69	188,107	0	14,677	1,953	21
22	33	Real Estate Taxes	Resident Days	1,413,604	69	35,872	0	14,677	372	22
23	34	Rent-Facility and Grounds	Resident Days	1,413,604	69	0	0	14,677	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,413,604	69	30,580	0	14,677	318	24
25	TOTALS					\$ 7,166,062	\$ 4,753,358		\$ 74,404	25

Facility Name & ID Number Bloomington Rehabilitation & Health Care Center # 0047415 Report Period Beginning: 1/1/2008 Ending: 2/31/2008

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 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

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	419,957	23	\$	18,384	\$	1	
2	2	Food	Resident Days	419,957	23	68	18,384	2	2	
3	3	Housekeeping	Resident Days	419,957	23		18,384		3	
4	4	Laundry	Resident Days	419,957	23		18,384		4	
5	5	Utilities	Resident Days	419,957	23		18,384		5	
6	6	Maintenance	Resident Days	419,957	23	22,929	10,000	18,384	801	6
7	7	Mgmt. Allocation of Benefits	Resident Days	419,957	23	7,067	18,384	247	7	
8	10	Nursing and Medical Records	Resident Days	419,957	23	6	18,384		8	
9	12	Social Services	Resident Days	419,957	23	187	18,384	7	9	
10	17	Administrative	Resident Days	419,957	23	45,582	45,582	18,384	1,593	10
11	19	Professional Services	Resident Days	419,957	23	58,812	18,384	2,055	11	
12	20	Dues, Fees, Subs & Promotions	Resident Days	419,957	23	997	18,384	35	12	
13	21	Clerical and General Office	Resident Days	419,957	23	112,798	18,384	3,942	13	
14	22	Employee Benefits & Payroll	Resident Days	419,957	23		18,384		14	
15	23	Inservice Training & Education	Resident Days	419,957	23	299	18,384	10	15	
16	24	Travel and Seminar	Resident Days	419,957	23	296	18,384	10	16	
17	25	Other Admin. Staff Transport.	Resident Days	419,957	23	106,105	18,384	3,708	17	
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	419,957	23		18,384		18	
19	27	Mgmt. Allocation of Benefits	Resident Days	419,957	23	32,211	18,384	1,126	19	
20	30	Depreciation	Resident Days	419,957	23	26,070	18,384	911	20	
21	32	Interest	Resident Days	419,957	23	212,765	18,384	7,436	21	
22	33	Real Estate Taxes	Resident Days	419,957	23		18,384		22	
23	34	Rent-Facility and Grounds	Resident Days	419,957	23		18,384		23	
24	35	Rent-Equipment & Vehicles	Resident Days	419,957	23		18,384		24	
25	TOTALS					\$ 626,192	\$ 55,582	\$ 21,883	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	Name of Lender	2		3	4	5	6		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	Bank of America		X	Mortgage	Varies	1/19/07	\$ 550,000	\$ 539,713	12/31/13	Varies	\$ 35,691	1				
2												2				
3							Interest Income Offset				(117)	3				
4							Home Office Allocation-PHC				7,436	4				
5							Home Office Allocation-PHO				1,953	5				
Working Capital																
6												6				
7												7				
8												8				
9	TOTAL Facility Related						\$ 550,000	\$ 539,713			\$ 44,963	9				
B. Non-Facility Related*																
10												10				
11												11				
12												12				
13												13				
14	TOTAL Non-Facility Related						\$	\$			\$	14				
15	TOTALS (line 9+line14)						\$ 550,000	\$ 539,713			\$ 44,963	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 (continued)

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 2007 report.		\$	26,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2007	\$	26,721	2
3. Under or (over) accrual (line 2 minus line 1).		\$	721	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	28,000	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			372	
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.		\$	29,093	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	_____	8
	2004	_____	9
	2005	24,814	10
	2006	25,199	11
	2007	26,721	12

Accrual based on prior year tax bill.

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2007	\$	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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Bloomington Rehabilitation & Health Care Center COUNTY McLean

FACILITY IDPH LICENSE NUMBER 0047415

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 2007 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 2007.

(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>21-16-128-012</u>	<u>Long-Term Care Facility</u>	\$ <u>26,720.94</u>	\$ <u>26,720.94</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>26,720.94</u>	\$ <u>26,720.94</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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: 15,386 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>66,211</u>	<u>2005</u>	<u>\$ 87,500</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	66,211		\$ 87,500	3

Facility Name & ID Number **Bloomington Rehabilitation & Health Care Center**

0047415

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

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	78	2005	1972	\$ 528,930	\$	30	\$ 20,800	\$ 20,800	\$ 72,800	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Land improvement		2005	13,000		15	867	867	3,034	9
10	Sign		2005	458		10	46	46	161	10
11	Sidewalks		2005	3,850		15	257	257	642	11
12	Roof		2007	9,076		20	454	454	908	12
13	Backflow		2008	9,779		25	196	196	196	13
14	Carpet		2008	6,911		7	494	494	494	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	Building Booked				20,826			(20,826)		28
29	Building Improvement Booked				1,463			(1,463)		29
30										30
31										31
32	2008-Home Office Allocation-Land Improvements			510			33	33		32
33	2008-Home Office Allocation-Building Improvements			7,621			183	183		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)		\$ 580,135	\$ 22,289		\$ 23,330	\$ 1,041	\$ 78,235	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	\$ 118,287	\$ 17,693	\$ 16,805	\$ (888)	3-10 yrs.	\$ 59,792	71
72	Current Year Purchases	2,375	225	119	(106)	10 yrs.	119	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			3,688	3,688			74
75	TOTALS	\$ 120,662	\$ 17,918	\$ 20,612	\$ 2,694		\$ 59,911	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)	\$ 788,297	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 40,207	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 43,942	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 3,735	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 138,146	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					87
88	N/A				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								6
7	TOTAL				\$			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: \$ 4,797 Description: See Attached 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	Facility	Ford E250 Van	\$ 1,831	\$ 21,970	17
18					18
19					19
20					20
21	TOTAL		\$ 1,831	\$ 21,970	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. _____ /2009 \$ _____

13. _____ /2010 \$ _____

14. _____ /2011 \$ _____

* 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.

**Bloomington Rehabilitation & Health Care Center
0047415**

Period Beginning 1/1/2008

Period End 12/31/2008

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$ 637
Dishwasher	708
Copier	3,134
Home Office Allocation	318
	<u>4,797</u>

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	\$	5,569	\$ 83,534	\$	5,569	\$ 83,534	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,158	17,377		1,158	17,377	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		8,299	124,484	229	8,299	124,713	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				28,984		28,984	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____									13
14	TOTAL			\$	15,026	\$ 225,395	\$ 29,213	15,026	\$ 254,608	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 **Bloomington Rehabilitation & Health Care Center**

0047415

Report Period Beginning: **1/1/2008**

Ending:

12/31/2008

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2008**

(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	\$ (499,499)	\$ (499,499)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>N/A</u>)	411,294	411,294	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	19,444	19,444	6
7	Other Prepaid Expenses	7,588	7,588	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): _____			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (61,173)	\$ (61,173)	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	100,500	87,500	13
14	Buildings, at Historical Cost	520,000	536,551	14
15	Leasehold Improvements, at Historical Cost	25,766	43,584	15
16	Equipment, at Historical Cost	121,120	120,662	16
17	Accumulated Depreciation (book methods)	(127,390)	(138,146)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify): _____			22
23	Other(specify): _____			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 639,996	\$ 650,151	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 578,823	\$ 588,978	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 376,600	\$ 376,600	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	20,113	20,113	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,395	3,395	31
32	Accrued Real Estate Taxes(Sch.IX-B)	28,000	28,000	32
33	Accrued Interest Payable	2,696	2,696	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	19,006	19,006	36
37	<u>Due to Related Parties</u>	122,752	122,752	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 572,562	\$ 572,562	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	539,713	539,713	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)	\$ 539,713	\$ 539,713	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,112,275	\$ 1,112,275	46
47	TOTAL EQUITY(page 18, line 24)	\$ (533,452)	\$ (523,297)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 578,823	\$ 588,978	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (265,246)	1
2	Restatements (describe):		2
3	Rounding	2	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (265,244)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(268,208)	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)	\$ (268,208)	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)	\$ (533,452)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1

Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 1,644,375	1
2	Discounts and Allowances for all Levels	83,209	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,727,584	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	339,732	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 339,732	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	2,218	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	50,162	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	1,398	20
21	Other Medical Services	2,623	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 56,401	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	117	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 117	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Revenue</u>	1,747	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,747	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,125,581	30

2

Expenses		Amount	
A. Operating Expenses			
31	General Services	482,320	31
32	Health Care	1,029,156	32
33	General Administration	537,736	33
B. Capital Expense			
34	Ownership	131,068	34
C. Ancillary Expense			
35	Special Cost Centers	170,687	35
36	Provider Participation Fee	42,822	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,393,789	40
41	Income before Income Taxes (line 30 minus line 40)**	(268,208)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (268,208)	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 part of 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 Bloomington Rehabilitation & Health Care Center

0047415

Report Period Beginning: 1/1/2008

Ending: 12/31/2008

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,269	2,269	\$ 63,724	\$ 28.08	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,521	3,585	94,467	26.35	3
4	Licensed Practical Nurses	8,966	9,228	183,980	19.94	4
5	CNAs & Orderlies	25,160	26,010	292,223	11.24	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,969	2,081	25,439	12.22	9
10	Activity Assistants	101	101	741	7.34	10
11	Social Service Workers	602	634	7,879	12.43	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	24,441	11.75	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,215	9,329	79,327	8.50	15
16	Dishwashers					16
17	Maintenance Workers	3,248	3,416	49,935	14.62	17
18	Housekeepers	6,205	6,587	55,144	8.37	18
19	Laundry	2,960	3,083	28,482	9.24	19
20	Administrator	2,080	2,080	62,128	29.87	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,968	2,152	33,030	15.35	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: <u>Marketing</u>	1,695	1,695	25,177	14.85	32
33	Other(specify) <u>Care Plan Coord.</u>	2,080	2,080	47,047	22.62	33
34	TOTAL (lines 1 - 33)	74,119	76,410	\$ 1,073,164 *	\$ 14.04	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 17,250	9(3)	36
37	Medical Records Consultant	Monthly 1,080	10(3)	37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 1,200	10(3)	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 19,530		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	193 \$ 7,587	10(3)	50
51	Licensed Practical Nurses	212 7,355	10(3)	51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)	405 \$ 14,942		53

Bloomington Rehabilitation & Health Care Center

0047415

Period Beginning 1/1/2008

Period End 12/31/2008

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Director of Nursing	2,269	2,269	63,724	28.08
Assistant Director of Nsg.				
Registered Nurses	3,521	3,585	94,467	26.35
Licensed Practical Nurses	8,966	9,228	183,980	19.94
Nurse Aides & Orderlies	25,160	26,010	292,223	11.24
Nurse Aide Trainees				
Licensed Therapist				
Activity Director	1,969	2,081	25,439	12.22
Activity Assistants	84	84	557	6.63
Social Service Workers	602	634	7,879	12.43
Dietician				
Food Service Supervisor	2,080	2,080	24,441	11.75
Head Cook				
Cook Helpers/Assistants	9,215	9,329	79,327	8.50
Dishwashers				
Maintenance Workers	3,248	3,416	49,935	14.62
Housekeepers	6,205	6,587	55,144	8.37
Laundry	2,960	3,083	28,482	9.24
Administrator	2,080	2,080	62,128	29.87
Assistant Administrator				
Other Administrative				
Office Manager	1,968	2,152	33,030	15.35
Clerical				
Vocational Instruction				
Academic Instruction				
Medical Director				
Qualified Mental Retard.Prof.				
Resident Services Coordinator				
Habilitation Aides				
Medical Records				
Care Plan Coordinator	2,080	2,080	47,047	22.62
Marketing	1,695	1,695	25,177	14.85
Transportation	17	17	184	10.82
TOTAL (lines 1 - 35)	74,119	76,410	1,073,164	

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		
Janice Kindred	Administrator	0	\$ 62,128	Workers' Compensation Insurance	\$ 23,876	IDPH License Fee	\$ 1,990		
				Unemployment Compensation Insurance	30,025	Advertising: Employee Recruitment	2,904		
				FICA Taxes	79,916	Health Care Worker Background Check (Indicate # of checks performed)			
				Employee Health Insurance	152,332	Patient Background Checks	92		
				Employee Meals		Miscellaneous Licenses & Permits	576		
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Dues & Subscriptions	631		
				Employee Relations	1,317	IHCA Dues	2,585		
				Employee Retirement	10	Home Office Allocation	742		
				Smoking Cessation Reimbursement	60				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 62,128	TOTAL (agree to Schedule V, line 22, col.8)		\$ 287,536	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 9,895
B. Administrative - Other							Less: Public Relations Expense		(453)
Description			Amount				Non-allowable advertising		()
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 103,000				Yellow page advertising		()
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 103,000						
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		\$ 2,700				Out-of-State Travel	\$	
Verizon North	Computer Services		560						
LTC Solutions	Computer Services		1,600				In-State Travel		
				N/A					
							Seminar Expense		
							Home Office Allocation	165	
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 4,860	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)		\$ 165

* Attach copy of IMRF notifications

**See instructions.

Bloomington Rehabilitation & Health Care Center

0047415

Period Beginning 1/1/2008

Period End 12/31/2008

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		4,860

Home Office Allocation

Heyl, Royster, Voelker & Allen	Legal	167
GoffWilson, P.A.	Legal	278
Ginoli & Company	Accountants	2,328
RSM McGladrey	Accountants	6
Miscellaneous Vendors	Computer Services	32
Emdeon Business Services	Computer Services	45
Advanced Answers on Demand	Computer Services	527
Access 2 Go	Computer Services	155
Ivans	Computer Services	360
Kemper Technology	Computer Services	285
VisionShare	Computer Services	30
Logmein	Computer Services	22
Comm Net Communiations	Computer Services	8
Charter Communications	Computer Services	7
Advanced System Designs	Computer Services	10
Consolidated Communications	Computer Services	6
Miscellaneous Vendors	Miscellaneous	81

Total (agree to Schedule V, line 19, column 8)		<u>9,207</u>
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Bloomington Rehabilitation & Health Care Center

0047415

Period Beginning 1/1/2008

Period End 12/31/2008

XIX. SUPPORT SCHEDULES

Schedule 21B

A. Administrative Salaries

<u>Name</u>	<u>Function</u>	<u>Ownership %</u>	<u>Amount</u>
Janice Kindred	Administrator	0	62,128
	Total		<u><u>62,128</u></u>

Facility Name & ID Number Bloomington Rehabilitation & Health Care Center# 0047415Report Period Beginning: 1/1/2008Ending: 12/31/2008**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. 2,585 -IHCA
- (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? No
- (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. \$ 6,410 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? N/A
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. \$ 42,822
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. \$ 2,218
- (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. \$ No
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? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. \$ No
- (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 currently 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