



Facility Name & ID Number Charleston Rehabilitation & Health Care Center

# 0048546 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	45	Skilled (SNF)	45	16,470	1
2		Skilled Pediatric (SNF/PED)			2
3	94	Intermediate (ICF)	94	34,404	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	139	TOTALS	139	50,874	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			3,223	3,223	8
9	SNF/PED					9
10	ICF	14,809	4,925		19,734	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,809	4,925	3,223	22,957	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 45.13%

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 11/28/2006

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

YES  Date 11/28/2006 NO

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

YES  NO  If YES, enter number of beds certified 14 and days of care provided 2,786

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

Is your fiscal year identical to your tax year? YES  NO

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

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

Facility Name & ID Number Charleston Rehabilitation & Health Care Cer # 0048546 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
	<b>A. General Services</b>										
1	Dietary	114,400	15,330		129,730		129,730	4,079	133,809		1
2	Food Purchase		144,280		144,280		144,280	(3,966)	140,314		2
3	Housekeeping	74,425	13,620		88,045		88,045	30	88,075		3
4	Laundry	38,657	9,533		48,190		48,190	2	48,192		4
5	Heat and Other Utilities			164,668	164,668		164,668	423	165,091		5
6	Maintenance	28,754	8,124	23,476	60,354		60,354	2,493	62,847		6
7	Other (specify):* <u>Home Off. Ben. All.</u>							1,003	1,003		7
8	<b>TOTAL General Services</b>	<b>256,236</b>	<b>190,887</b>	<b>188,144</b>	<b>635,267</b>		<b>635,267</b>	<b>4,064</b>	<b>639,331</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			10,200	10,200		10,200		10,200		9
10	Nursing and Medical Records	820,528	99,800	4,831	925,159		925,159	4,952	930,111		10
10a	Therapy		47	331,299	331,346		331,346		331,346		10a
11	Activities	14,458	396	475	15,329		15,329		15,329		11
12	Social Services	21,264	60		21,324		21,324		21,324		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Off. Ben. All.</u>							1,236	1,236		15
16	<b>TOTAL Health Care and Programs</b>	<b>856,250</b>	<b>100,303</b>	<b>346,805</b>	<b>1,303,358</b>		<b>1,303,358</b>	<b>6,188</b>	<b>1,309,546</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	55,347			55,347		55,347	31,756	87,103		17
18	Directors Fees										18
19	Professional Services			5,990	5,990		5,990	5,909	11,899		19
20	Dues, Fees, Subscriptions & Promotions			6,031	6,031		6,031	843	6,874		20
21	Clerical & General Office Expenses	38,711	5,198	14,205	58,114		58,114	43,243	101,357		21
22	Employee Benefits & Payroll Taxes			181,510	181,510		181,510		181,510		22
23	Inservice Training & Education							313	313		23
24	Travel and Seminar							243	243		24
25	Other Admin. Staff Transportation			7,903	7,903		7,903	3,929	11,832		25
26	Insurance-Prop.Liab.Malpractice			26,445	26,445		26,445	297	26,742		26
27	Other (specify):* <u>Home Off. Ben. All.</u>							11,345	11,345		27
28	<b>TOTAL General Administration</b>	<b>94,058</b>	<b>5,198</b>	<b>242,084</b>	<b>341,340</b>		<b>341,340</b>	<b>97,878</b>	<b>439,218</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,206,544</b>	<b>296,388</b>	<b>777,033</b>	<b>2,279,965</b>		<b>2,279,965</b>	<b>108,130</b>	<b>2,388,095</b>		<b>29</b>

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

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

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			130,289	130,289		130,289	(23,204)	107,085			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			174,882	174,882		174,882	13,350	188,232			32
33	Real Estate Taxes			38,584	38,584		38,584	582	39,166			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			3,095	3,095		3,095	555	3,650			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			346,850	346,850		346,850	(8,717)	338,133			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		91,047		91,047		91,047		91,047			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			76,313	76,313		76,313		76,313			42
43	Other (specify):* Non-allowable Cost		2,239	84,764	87,003		87,003	(87,003)				43
44	<b>TOTAL Special Cost Centers</b>		93,286	161,077	254,363		254,363	(87,003)	167,360			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,206,544	389,674	1,284,960	2,881,178		2,881,178	12,410	2,893,588			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	(4,033)	2		4
5	Telephone, TV & Radio in Resident Rooms	(11,717)	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	(28,700)	30		9
10	Interest and Other Investment Income	(62)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(284)	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	(2,937)	43		18
19	Entertainment				19
20	Contributions	(425)	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	(54,587)	43		24
25	Fund Raising, Advertising and Promotional	(7,866)	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	(12,116)	Various		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (122,727)		\$	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)	135,137	Various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 135,137		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 12,410		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

Charleston Rehabilitation & Health Care Center

ID# 0048546

Report Period Beginning: 1/1/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (4,245)	43	1
2	X-Rays-Part A	(3,963)	43	2
3	Offset Miscellaneous Nursing Supplies Revenue	(2,128)	10	3
4	Resident Flowers	(979)	43	4
5	Offset Miscellaneous Office Supplies Revenue	(156)	21	5
6	Offset Chamber of Commerce Dues	(645)	20	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
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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	<b>Total</b>	(12,116)		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%	\$ 4,079	\$ 4,079	1	
2	V	2 Food		Petersen Health Care, Inc.	100.00%	67	67	2	
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	30	30	3	
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	2	2	4	
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	423	423	5	
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	2,493	2,493	6	
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,003	1,003	7	
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	7,080	7,080	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%	1,236	1,236	10	
11	V	17 Administrative		Petersen Health Care, Inc.	100.00%	31,756	31,756	11	
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	3,584	3,584	12	
13	V							13	
14	Total		\$			\$ 51,753	\$ *	51,753	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%	\$ 1,105	\$	1,105	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	39,851		39,851	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	242		242	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	243		243	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	3,138		3,138	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	191		191	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	11,345		11,345	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	4,342		4,342	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	3,054		3,054	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	582		582	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%	496		496	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		\$			\$ 64,589	\$ *	64,589	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1 Dietary	\$	Petersen Companies, LLC	100.00%	\$ 0	\$	15	
16	V	2 Food		Petersen Companies, LLC	100.00%	0		16	
17	V	3 Housekeeping		Petersen Companies, LLC	100.00%	0		17	
18	V	4 Laundry		Petersen Companies, LLC	100.00%	0		18	
19	V	5 Utilities		Petersen Companies, LLC	100.00%	0		19	
20	V	6 Maintenance		Petersen Companies, LLC	100.00%	0		20	
21	V	7 Mgmt. Allocation of Benefits		Petersen Companies, LLC	100.00%	0		21	
22	V	10 Nursing and Medical Records		Petersen Companies, LLC	100.00%	0		22	
23	V	10A Therapy		Petersen Companies, LLC	100.00%	0		23	
24	V	15 Mgmt. Allocation of Benefits		Petersen Companies, LLC	100.00%	0		24	
25	V	17 Administrative		Petersen Companies, LLC	100.00%	0		25	
26	V	19 Professional Services		Petersen Companies, LLC	100.00%	2,325	2,325	26	
27	V	20 Dues, Fees, Subs & Promotions		Petersen Companies, LLC	100.00%	383	383	27	
28	V	21 Clerical and General Office		Petersen Companies, LLC	100.00%	3,548	3,548	28	
29	V	23 Inservice Training & Education		Petersen Companies, LLC	100.00%	71	71	29	
30	V	24 Travel and Seminar		Petersen Companies, LLC	100.00%	0		30	
31	V	25 Other Admin. Staff Transport.		Petersen Companies, LLC	100.00%	791	791	31	
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Companies, LLC	100.00%	106	106	32	
33	V	27 Mgmt. Allocation of Benefits		Petersen Companies, LLC	100.00%	0		33	
34	V	30 Depreciation		Petersen Companies, LLC	100.00%	1,154	1,154	34	
35	V	32 Interest		Petersen Companies, LLC	100.00%	10,358	10,358	35	
36	V	33 Real Estate Taxes		Petersen Companies, LLC	100.00%	0		36	
37	V	34 Rent-Facility and Grounds		Petersen Companies, LLC	100.00%	0		37	
38	V	35 Rent-Equipment & Vehicles		Petersen Companies, LLC	100.00%	59	59	38	
39	Total		\$			\$ 18,795	\$ *	18,795	39

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

Facility Name & ID Number Charleston Rehabilitation & Health Care Ce # 0048546 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	1,796,918	0.95	1.59	Salary	31,756	L17, C7	1
2											2
3											3
4											4
5		See Attached Schedule 7A									5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 31,756		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 Charleston Rehabilitation & Health Care Center

# 0048546

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	22,957	\$ 4,079	1
2	2	Food	Resident Days	1,413,604	69	4,125	0	22,957	67	2
3	3	Housekeeping	Resident Days	1,413,604	69	1,859	0	22,957	30	3
4	4	Laundry	Resident Days	1,413,604	69	110	0	22,957	2	4
5	5	Utilities	Resident Days	1,413,604	69	26,036	0	22,957	423	5
6	6	Maintenance	Resident Days	1,413,604	69	153,551	100,245	22,957	2,493	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	61,774	0	22,957	1,003	7
8	10	Nursing and Medical Records	Resident Days	1,413,604	69	436,084	432,530	22,957	7,080	8
9	10A	Therapy	Resident Days	1,413,604	69	0	0	22,957	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	76,136	0	22,957	1,236	10
11	17	Administrative	Resident Days	1,413,604	69	1,955,999	1,956,000	22,957	31,756	11
12	19	Professional Services	Resident Days	1,413,604	69	220,762	0	22,957	3,584	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,413,604	69	68,094	0	22,957	1,105	13
14	21	Clerical and General Office	Resident Days	1,413,604	69	2,454,596	2,013,896	22,957	39,851	14
15	23	Inservice Training & Education	Resident Days	1,413,604	69	14,912	0	22,957	242	15
16	24	Travel and Seminar	Resident Days	1,413,604	69	14,938	0	22,957	243	16
17	25	Other Admin. Staff Transport.	Resident Days	1,413,604	69	193,264	0	22,957	3,138	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,413,604	69	11,767	0	22,957	191	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	698,810	0	22,957	11,345	19
20	30	Depreciation	Resident Days	1,413,604	69	267,426	0	22,957	4,342	20
21	32	Interest	Resident Days	1,413,604	69	188,107	0	22,957	3,054	21
22	33	Real Estate Taxes	Resident Days	1,413,604	69	35,872	0	22,957	582	22
23	34	Rent-Facility and Grounds	Resident Days	1,413,604	69	0	0	22,957	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,413,604	69	30,580	0	22,957	496	24
25	TOTALS					\$ 7,166,062	\$ 4,753,358		\$ 116,342	25

Facility Name & ID Number Charleston Rehabilitation & Health Care Center# 0048546

Report Period Beginning:

1/1/2008Ending: 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 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	227,342	13	\$	22,957	\$	1
2	2	Food	Resident Days	227,342	13		22,957		2
3	3	Housekeeping	Resident Days	227,342	13		22,957		3
4	4	Laundry	Resident Days	227,342	13		22,957		4
5	5	Utilities	Resident Days	227,342	13		22,957		5
6	6	Maintenance	Resident Days	227,342	13		22,957		6
7	7	Mgmt. Allocation of Benefits	Resident Days	227,342	13		22,957		7
8	10	Nursing and Medical Records	Resident Days	227,342	13		22,957		8
9	10A	Therapy	Resident Days	227,342	13		22,957		9
10	15	Mgmt. Allocation of Benefits	Resident Days	227,342	13		22,957		10
11	17	Administrative	Resident Days	227,342	13		22,957		11
12	19	Professional Services	Resident Days	227,342	13	23,031	22,957	2,325	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	227,342	13	3,794	22,957	383	13
14	21	Clerical and General Office	Resident Days	227,342	13	35,146	22,957	3,548	14
15	23	Inservice Training & Education	Resident Days	227,342	13	706	22,957	71	15
16	24	Travel and Seminar	Resident Days	227,342	13		22,957		16
17	25	Other Admin. Staff Transport.	Resident Days	227,342	13	7,835	22,957	791	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	227,342	13	1,053	22,957	106	18
19	27	Mgmt. Allocation of Benefits	Resident Days	227,342	13		22,957		19
20	30	Depreciation	Resident Days	227,342	13	11,428	22,957	1,154	20
21	32	Interest	Resident Days	227,342	13	102,603	22,957	10,358	21
22	33	Real Estate Taxes	Resident Days	227,342	13		22,957		22
23	34	Rent-Facility and Grounds	Resident Days	227,342	13		22,957		23
24	35	Rent-Equipment & Vehicles	Resident Days	227,342	13	585	22,957	59	24
25	TOTALS					\$ 186,181	\$	\$ 18,795	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		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			
<b>A. Directly Facility Related</b>																	
<b>Long-Term</b>																	
1	Associated Bank		x	Mortgage	\$18,283.65	9/28/2006	\$ 2,167,200	\$ 2,059,768	9/28/2009	0.0800	\$ 169,755	1					
2												2					
3							Interest Income Offset				(62)	3					
4							Home Office Allocation-PHC				3,054	4					
5							Home Office Allocation-PC				10,358	5					
<b>Working Capital</b>																	
6							Amortization Expense				5,127	6					
7												7					
8												8					
9	<b>TOTAL Facility Related</b>				\$18,283.65		\$ 2,167,200	\$ 2,059,768			\$ 188,232	9					
<b>B. Non-Facility Related*</b>																	
10												10					
11												11					
12												12					
13												13					
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14					
15	<b>TOTALS (line 9+line14)</b>						\$ 2,167,200	\$ 2,059,768			\$ 188,232	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.		\$	<b>44,000</b>	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	\$	<b>40,584</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(3,416)</b>	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>42,000</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		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. <b>Home Office Allocation</b>			<b>582</b>	
<b>TOTAL REFUND</b> \$ _____ For _____ Tax Year. <b>(Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>39,166</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	8
	2004	9
	2005	10
	2006	<b>41,927</b> 11
	2007	<b>40,584</b> 12

Accrual based on prior year tax bill.

<b>FOR BHF USE ONLY</b>		
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 Charleston Rehabilitation & Health Care Center COUNTY Coles

FACILITY IDPH LICENSE NUMBER 0048546

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>02-2-13403-000</u>	<u>Long-Term Care Facility</u>	\$ <u>40,584.08</u>	\$ <u>40,584.08</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>40,584.08</u>	\$ <u>40,584.08</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.

Facility Name & ID Number Charleston Rehabilitation & Health Care Center

# 0048546

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 35,515 B. General Construction Type: Exterior Brick Frame Concrete Block 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:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>146,070</u>	<u>2006</u>	<u>\$ 75,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>146,070</b>		<b>\$ 75,000</b>	<b>3</b>

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

# **0048546**

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	139	2006	1970	\$ 2,029,000	\$	30	\$ 67,633	\$ 67,633	\$ 169,083	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Original Land Improvements		2006	20,000		15	1,333	1,333	3,332	9
10	Landscaping		2006	9,952		15	663	663	1,658	10
11	Sewer Pipe		2006	4,602		15	307	307	767	11
12	Carpeting-Lobby		2007	9,825		10	983	983	1,474	12
13	Blinds/Window Treatments		2007	1,807		10	181	181	271	13
14	Fire Alarm		2007	1,384		15	92	92	138	14
15	Fencing		2008	10,765		39	138	138	138	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				81,160			(81,160)		28
29	Building Improvement Booked				4,586			(4,586)		29
30										30
31										31
32	2008-Home Office Allocation-Land Improvements			797			51	51		32
33	2008-Home Office Allocation-Building Improvements			11,916			286	286		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)	\$ 2,100,048	\$ 85,746		\$ 71,667	\$ (14,079)	\$ 176,861	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	\$ 299,027	\$ 44,174	\$ 29,903	\$ (14,271)	10	\$ 74,341	71
72	Current Year Purchases	7,128	369	356	(13)	10	356	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			5,159	5,159			74
75	TOTALS	\$ 306,155	\$ 44,543	\$ 35,418	\$ (9,125)		\$ 74,697	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)	\$ 2,481,203	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 130,289	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 107,085	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (23,204)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 251,558	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: \$ 3,650 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			\$ _____	\$ _____	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. \_\_\_\_\_ /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.

**Charleston Rehabilitation & Health Care Center**

**0048546**

**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	\$ 858
Copier	2,237
Home Office Allocation	555
	<u>3,650</u>
	<u><u>3,650</u></u>

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**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)	
<b>TOTAL TRAINED</b>	

- (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	\$	8,058	\$ 120,869	\$	8,058	\$ 120,869	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		837	12,556		837	12,556	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		13,192	197,874	47	13,192	197,921	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				91,047		91,047	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	<b>TOTAL</b>			\$	22,087	\$ 331,299	\$ 91,094	22,087	\$ 422,393	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.



**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>316,714</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>316,714</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>626,068</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>626,068</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>942,782</b>	<b>24</b> *

\* 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	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 2,691,735	1
2	Discounts and Allowances for all Levels	134,339	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,826,074	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	512,538	6
7	Oxygen	6,965	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 519,503	8
	<b>C. Other Operating Revenue</b>		
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	4,033	14
15	Telephone, Television and Radio	1,152	15
16	Rental of Facility Space		16
17	Sale of Drugs	129,479	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	19,784	20
21	Other Medical Services	4,875	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 159,323	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	62	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 62	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Miscellaneous Revenue</u>	2,284	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 2,284	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,507,246	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	635,267	31
32	Health Care	1,303,358	32
33	General Administration	341,340	33
	<b>B. Capital Expense</b>		
34	Ownership	346,850	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	178,050	35
36	Provider Participation Fee	76,313	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,881,178	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	626,068	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 626,068	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 Charleston Rehabilitation & Health Care Center

# 0048546

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	947	947	\$ 23,167	\$ 24.46	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,402	4,792	113,300	23.64	3
4	Licensed Practical Nurses	10,697	10,849	190,552	17.56	4
5	CNAs & Orderlies	41,047	41,775	443,228	10.61	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,148	1,300	13,127	10.10	9
10	Activity Assistants	184	184	1,331	7.23	10
11	Social Service Workers	1966	2,062	21,264	10.31	11
12	Dietician					12
13	Food Service Supervisor	1,714	1,714	21,325	12.44	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,082	11,220	93,075	8.30	15
16	Dishwashers					16
17	Maintenance Workers	2,071	2,095	28,754	13.73	17
18	Housekeepers	7,449	7,825	74,425	9.51	18
19	Laundry	4,757	4,874	38,657	7.93	19
20	Administrator	1,899	1,899	55,347	29.15	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,080	2,080	38,711	18.61	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 Care(specify)					32
33	Other(specify) <u>Care Plan Coord.</u>	2,547	2,587	50,281	19.44	33
34	TOTAL (lines 1 - 33)	93,990	96,203	\$ 1,206,544 *	\$ 12.54	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 10,200	9(3)	36
37	Medical Records Consultant	Monthly 1,033	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)	\$ 12,433		49

**C. CONTRACT NURSES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses			50
51	Licensed Practical Nurses	N/A		51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)	\$		53

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Araceli Henson	Administrator	0	\$ 22,405	Workers' Compensation Insurance	\$ 28,010	IDPH License Fee	\$ 1,990		
Brenda Reed	Administrator	0	32,942	Unemployment Compensation Insurance	24,242	Advertising: Employee Recruitment	1,378		
				FICA Taxes	90,412	Health Care Worker Background Check (Indicate # of checks performed )			
				Employee Health Insurance	36,452	Patient Background Checks	20 200		
				Employee Meals		Miscellaneous Licenses & Permits	518		
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Dues & Subscriptions	615		
				Employee Relations	1,727	IHCA Dues	1,330		
				Employee Retirement	667	Home Office Allocation	1,488		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 55,347	TOTAL (agree to Schedule V, line 22, col.8)		\$ 181,510	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 6,874
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
N/A			\$	N/A			Out-of-State Travel	\$	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL			In-State Travel		
C. Professional Services							Seminar Expense		
Vendor/Payee	Type		Amount				Home Office Allocation	243	
E-Health Data Solutions	Computer Services		\$ 3,285				Entertainment Expense (agree to Sch. V, line 24, col. 8)		
LTC Solutions	Computer Services		1,600				TOTAL	\$ 243	
Mediacom	Computer Services		605						
Terry Linder	Architect		500						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 5,990						

\* Attach copy of IMRF notifications

\*\*See instructions.

**Charleston Rehabilitation & Health Care Center**

**0048546**

**Period Beginning 1/1/2008**

**Period End 12/31/2008**

**Schedule 21A**

**XIX. SUPPORT SCHEDULE**

**C. Professional Services**

<b>Vendor/Payee</b>	<b>Type</b>	<b>Amount</b>
Total (agree to Schedule V, line 19, column 3)		5,990

**Home Office Allocation**

Heyl, Royster, Voelker & Allen	Legal	130
GoffWilson, P.A.	Legal	435
Ginoli & Company	Accountants	3,382
RSM McGladrey	Accountants	10
Miscellaneous Vendors	Computer Services	51
Emdeon Business Services	Computer Services	70
Advanced Answers on Demand	Computer Services	824
Access 2 Go	Computer Services	243
Ivans	Computer Services	126
Kemper Technology	Computer Services	446
VisionShare	Computer Services	48
Logmein	Computer Services	34
Comm Net Communiations	Computer Services	13
Charter Communications	Computer Services	11
Advanced System Designs	Computer Services	16
Consolidated Communications	Computer Services	10
Miscellaneous Vendors	Miscellaneous	60

Total (agree to Schedule V, line 19, column 8)		<u>11,899</u>
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Facility Name & ID Number Charleston Rehabilitation & Health Care Center# 0048546Report 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. 1,330 -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. \$ 16,857 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. \$ 76,313  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 4,033
- (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? 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