



Facility Name & ID Number Cisne Rehabilitation & Health Care Center

# 0047423 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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	35	Intermediate (ICF)	35	12,810	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	35	TOTALS	35	12,810	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF	8,890	1,569		10,459
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	8,890	1,569		10,459

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.65%

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)

Meals on Wheels

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES

NO

Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES

NO

I. On what date did you start providing long term care at this location?

Date started 10/1/2005

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

YES

Date 10/1/2005

NO

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

YES

NO

If YES, enter number of beds certified 0 and days of care provided 0

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL

MODIFIED

CASH\*

CASH\*

Is your fiscal year identical to your tax year?

YES

NO

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

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

Facility Name & ID Number Cisne Rehabilitation & Health Care Center # 0047423 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	78,493	6,816		85,309		85,309	1,859	87,168		1
2	Food Purchase		60,435		60,435		60,435	(4,912)	55,523		2
3	Housekeeping	31,486	7,212		38,698		38,698	14	38,712		3
4	Laundry	15,494	4,720		20,214		20,214	1	20,215		4
5	Heat and Other Utilities			38,002	38,002		38,002	764	38,766		5
6	Maintenance	156	4,870	12,404	17,430		17,430	1,312	18,742		6
7	Other (specify):* <u>Home Off. Ben. All.</u>							457	457		7
8	<b>TOTAL General Services</b>	125,629	84,053	50,406	260,088		260,088	(505)	259,583		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			8,400	8,400		8,400		8,400		9
10	Nursing and Medical Records	378,249	23,795	600	402,644		402,644	3,227	405,871		10
10a	Therapy	6,265	414		6,679		6,679		6,679		10a
11	Activities	21,082	590	138	21,810		21,810		21,810		11
12	Social Services	20,057			20,057		20,057	5	20,062		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Off. Ben. All.</u>							563	563		15
16	<b>TOTAL Health Care and Programs</b>	425,653	24,799	9,138	459,590		459,590	3,795	463,385		16
	<b>C. General Administration</b>										
17	Administrative	34,604		49,000	83,604		83,604	(33,393)	50,211		17
18	Directors Fees										18
19	Professional Services			7,221	7,221		7,221	3,098	10,319		19
20	Dues, Fees, Subscriptions & Promotions			2,809	2,809		2,809	529	3,338		20
21	Clerical & General Office Expenses		2,967	8,249	11,216		11,216	20,718	31,934		21
22	Employee Benefits & Payroll Taxes			78,022	78,022		78,022		78,022		22
23	Inservice Training & Education			123	123		123	117	240		23
24	Travel and Seminar			70	70		70	118	188		24
25	Other Admin. Staff Transportation			5,440	5,440		5,440	4,072	9,512		25
26	Insurance-Prop.Liab.Malpractice			6,830	6,830		6,830	87	6,917		26
27	Other (specify):* <u>Home Off. Ben. All.</u>							5,972	5,972		27
28	<b>TOTAL General Administration</b>	34,604	2,967	157,764	195,335		195,335	1,318	196,653		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	585,886	111,819	217,308	915,013		915,013	4,608	919,621		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 &amp; ID Number

Cisne Rehabilitation &amp; Health Care Center

#0047423

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	
	<b>D. Ownership</b>											
30	Depreciation			15,005	15,005		15,005	2,169	17,174			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			8,112	8,112		8,112	6,691	14,803			32
33	Real Estate Taxes			9,300	9,300		9,300	265	9,565			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			3,897	3,897		3,897	226	4,123			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			36,314	36,314		36,314	9,351	45,665			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			19,217	19,217		19,217		19,217			42
43	Other (specify):* Non-allowable Cost		1,482	(488)	994		994	(994)				43
44	<b>TOTAL Special Cost Centers</b>		1,482	18,729	20,211		20,211	(994)	19,217			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	585,886	113,301	272,351	971,538		971,538	12,965	984,503			45

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



Cisne Rehabilitation & Health Care Center

ID# 0047423

Report Period Beginning: 1/1/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Disallowed Special Events	(59)	43	1
2	Offset Miscellaneous Food Revenue	(4,944)	2	2
3	Offset Miscellaneous Office Supplies Revenue	(252)	21	3
4	Resident Flowers	(199)	43	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(5,454)		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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 1,859	\$ 1,859	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	30	30	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	14	14	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	1	1	4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	193	193	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	1,136	1,136	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	457	457	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	3,227	3,227	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%	563	563	10
11	V	17 Administrative	49,000	Petersen Health Care, Inc.	100.00%	14,472	(34,528)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	1,633	1,633	12
13	V							13
14	Total		\$ 49,000			\$ 23,585	\$ * (25,415)	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%	\$ 504	\$	504	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	18,161		18,161	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	110		110	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	111		111	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	1,430		1,430	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	87		87	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	5,170		5,170	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	1,979		1,979	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	1,392		1,392	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	265		265	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%	226		226	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		\$			\$ 29,435	\$ *	29,435	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1 Dietary	\$	Petersen Health Operations, LLC	100.00%	\$ 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%	571	571	20	
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	176	176	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%	5	5	23	
24	V	17 Administrative		Petersen Health Operations, LLC	100.00%	1,135	1,135	24	
25	V	19 Professional Services		Petersen Health Operations, LLC	100.00%	1,465	1,465	25	
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Operations, LLC	100.00%	25	25	26	
27	V	21 Clerical and General Office		Petersen Health Operations, LLC	100.00%	2,809	2,809	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%	7	7	29	
30	V	24 Travel and Seminar		Petersen Health Operations, LLC	100.00%	7	7	30	
31	V	25 Other Admin. Staff Transport.		Petersen Health Operations, LLC	100.00%	2,642	2,642	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%	802	802	33	
34	V	30 Depreciation		Petersen Health Operations, LLC	100.00%	649	649	34	
35	V	32 Interest		Petersen Health Operations, LLC	100.00%	5,299	5,299	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		\$			\$ 15,594	\$ *	15,594	39

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

Facility Name & ID Number Cisne Rehabilitation & Health Care Center # 0047423 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	1,814,202	0.43	0.72	Salary	14,472	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	\$ 14,472		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 Cisne Rehabilitation & Health Care Center# 0047423

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 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	10,459	\$ 1,859	1
2	2	Food	Resident Days	1,413,604	69	4,125	0	10,459	30	2
3	3	Housekeeping	Resident Days	1,413,604	69	1,859	0	10,459	14	3
4	4	Laundry	Resident Days	1,413,604	69	110	0	10,459	1	4
5	5	Utilities	Resident Days	1,413,604	69	26,036	0	10,459	193	5
6	6	Maintenance	Resident Days	1,413,604	69	153,551	100,245	10,459	1,136	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	61,774	0	10,459	457	7
8	10	Nursing and Medical Records	Resident Days	1,413,604	69	436,084	432,530	10,459	3,227	8
9	10A	Therapy	Resident Days	1,413,604	69	0	0	10,459	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	76,136	0	10,459	563	10
11	17	Administrative	Resident Days	1,413,604	69	1,955,999	1,956,000	10,459	14,472	11
12	19	Professional Services	Resident Days	1,413,604	69	220,762	0	10,459	1,633	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,413,604	69	68,094	0	10,459	504	13
14	21	Clerical and General Office	Resident Days	1,413,604	69	2,454,596	2,013,896	10,459	18,161	14
15	23	Inservice Training & Education	Resident Days	1,413,604	69	14,912	0	10,459	110	15
16	24	Travel and Seminar	Resident Days	1,413,604	69	14,938	0	10,459	111	16
17	25	Other Admin. Staff Transport.	Resident Days	1,413,604	69	193,264	0	10,459	1,430	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,413,604	69	11,767	0	10,459	87	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	698,810	0	10,459	5,170	19
20	30	Depreciation	Resident Days	1,413,604	69	267,426	0	10,459	1,979	20
21	32	Interest	Resident Days	1,413,604	69	188,107	0	10,459	1,392	21
22	33	Real Estate Taxes	Resident Days	1,413,604	69	35,872	0	10,459	265	22
23	34	Rent-Facility and Grounds	Resident Days	1,413,604	69	0	0	10,459	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,413,604	69	30,580	0	10,459	226	24
25	TOTALS					\$ 7,166,062	\$ 4,753,358		\$ 53,020	25

Facility Name & ID Number Cisne Rehabilitation & Health Care Center

# 0047423

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 Operations, LLC  
 Street Address 830 W. Trailcreek Drive  
 City / State / Zip Code Peoria, IL 61614  
 Phone Number (309) 691-8113  
 Fax Number (309) 691-8622

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	419,957	23	\$	10,459	\$	1
2	2	Food	Resident Days	419,957	23	68	10,459	2	2
3	3	Housekeeping	Resident Days	419,957	23		10,459		3
4	4	Laundry	Resident Days	419,957	23		10,459		4
5	5	Utilities	Resident Days	419,957	23		10,459		5
6	6	Maintenance	Resident Days	419,957	23	22,929	10,000	571	6
7	7	Mgmt. Allocation of Benefits	Resident Days	419,957	23	7,067	10,459	176	7
8	10	Nursing and Medical Records	Resident Days	419,957	23	6	10,459		8
9	12	Social Services	Resident Days	419,957	23	187	10,459	5	9
10	17	Administrative	Resident Days	419,957	23	45,582	45,582	1,135	10
11	19	Professional Services	Resident Days	419,957	23	58,812	10,459	1,465	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	419,957	23	997	10,459	25	12
13	21	Clerical and General Office	Resident Days	419,957	23	112,798	10,459	2,809	13
14	22	Employee Benefits & Payroll	Resident Days	419,957	23		10,459		14
15	23	Inservice Training & Education	Resident Days	419,957	23	299	10,459	7	15
16	24	Travel and Seminar	Resident Days	419,957	23	296	10,459	7	16
17	25	Other Admin. Staff Transport.	Resident Days	419,957	23	106,105	10,459	2,642	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	419,957	23		10,459		18
19	27	Mgmt. Allocation of Benefits	Resident Days	419,957	23	32,211	10,459	802	19
20	30	Depreciation	Resident Days	419,957	23	26,070	10,459	649	20
21	32	Interest	Resident Days	419,957	23	212,765	10,459	5,299	21
22	33	Real Estate Taxes	Resident Days	419,957	23		10,459		22
23	34	Rent-Facility and Grounds	Resident Days	419,957	23		10,459		23
24	35	Rent-Equipment & Vehicles	Resident Days	419,957	23		10,459		24
25	TOTALS					\$ 626,192	\$ 55,582	\$ 15,594	25

Facility Name & ID Number Cisne Rehabilitation & Health Care Center

# 0047423

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	Bank of America		X	Mortgage	Varies	1/19/07	\$ 125,000	\$ 122,595	9/20/2010	Varies	\$ 8,112	1								
2												2								
3												3								
4							Home Office Allocation-PHC				1,392	4								
5							Home Office Allocation-PHO				5,299	5								
<b>Working Capital</b>																				
6												6								
7												7								
8												8								
9	<b>TOTAL Facility Related</b>						\$ 125,000	\$ 122,595			\$ 14,803	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>						\$ 125,000	\$ 122,595			\$ 14,803	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>9,750</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>9,300</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(450)</b>	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>9,750</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>265</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>9,565</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	_____	8
	2004	_____	9
	2005	<b>8,946</b>	10
	2006	<b>9,312</b>	11
	2007	<b>9,300</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 Cisne Rehabilitation & Health Care Center COUNTY Wayne

FACILITY IDPH LICENSE NUMBER 0047423

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>03-50-065-006-00</u>	<u>Long-Term Care Facility</u>	\$ <u>84.92</u>	\$ <u>84.92</u>
2. <u>03-50-065-005</u>	<u>Long-Term Care Facility</u>	\$ <u>9,214.98</u>	\$ <u>9,214.98</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>9,299.90</u>	\$ <u>9,299.90</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 Cisne Rehabilitation & Health Care Center

# 0047423

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 9,413 B. General Construction Type: Exterior Brick Veneer Frame Wood Number of Stories 1

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

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

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

N/A

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

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

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

**XI. OWNERSHIP COSTS:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>75,359</u>	<u>2005</u>	<u>\$ 9,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>75,359</b>		<b>\$ 9,000</b>	<b>3</b>

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	35	2005	1970	\$ 176,500	\$	25	\$ 7,060	\$ 7,060	\$ 24,710
5									
6									
7									
8									
<b>Improvement Type**</b>									
9	Original Land Improvements	2005		10,000		15	667	667	2,334
10	Waterline	2005		1,634		15	109	109	381
11	Carpet	2006		1,269		5	254	254	635
12	Gutter	2006		2,750		25	110	110	275
13	Sewer Line	2007		3,500		20	175	175	263
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27					7,090			(7,090)	
28	Building Booked				1,373			(1,373)	
29	Building Improvement Booked								
30									
31									
32	2008-Home Office Allocation-Land Improvements			363			23	23	
33	2008-Home Office Allocation-Building Improvements			5,431			130	130	
34									
35									
36									

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9					
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation					
37		\$	\$		\$	\$	\$	37				
38								38				
39								39				
40								40				
41								41				
42								42				
43								43				
44								44				
45								45				
46								46				
47								47				
48								48				
49								49				
50								50				
51								51				
52								52				
53								53				
54								54				
55								55				
56								56				
57								57				
58								58				
59								59				
60								60				
61								61				
62								62				
63								63				
64								64				
65								65				
66								66				
67								67				
68								68				
69								69				
70	TOTAL (lines 4 thru 69)	\$	201,447	\$	8,463	\$	8,528	\$	65	\$	28,598	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	\$ 40,646	\$ 6,176	\$ 5,878	\$ (298)	5-10 yrs.	\$ 20,745	71
72	Current Year Purchases	2,792	366	140	(226)	10 yrs.	140	72
73	Fully Depreciated Assets							73
74	Home Office Allocation		2,628	2,628				74
75	TOTALS	\$ 43,438	\$ 9,170	\$ 8,646	\$ (524)		\$ 20,885	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)	\$ 253,885	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 17,633	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 17,174	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (459)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 49,483	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: \$ 4,123 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.

**Cisne Rehabilitation & Health Care Center**

**0047423**

**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	\$	968
Dishwasher		649
Laundry Equipment		59
Copier		2,221
Home Office Allocation		226
		<u>4,123</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(1)	161 hrs	\$ 4,478		\$		161	\$ 4,478	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(1), 10A(2)	66 hrs	1,787			414	66	2,201	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							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>			\$ 6,265		\$	\$ 414	227	\$ 6,679	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 Cisne Rehabilitation & Health Care Center

# 0047423

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*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ (433,627)	\$ (433,627)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>N/A</u> )	174,183	174,183	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	8,734	8,734	6
7	Other Prepaid Expenses	4,944	4,944	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): _____			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ (245,766)	\$ (245,766)	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	24,134	9,000	13
14	Buildings, at Historical Cost	176,500	181,931	14
15	Leasehold Improvements, at Historical Cost	4,019	19,516	15
16	Equipment, at Historical Cost	43,439	43,438	16
17	Accumulated Depreciation (book methods)	(46,327)	(49,483)	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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 201,765	\$ 204,402	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ (44,001)	\$ (41,364)	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 92,114	\$ 92,114	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	12,478	12,478	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,991	3,991	31
32	Accrued Real Estate Taxes(Sch.IX-B)	9,750	9,750	32
33	Accrued Interest Payable	613	613	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Payroll Withholdings</u>	12,059	12,059	36
37	<u>Due to Related Parties</u>	64,367	64,367	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 195,372	\$ 195,372	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable	122,595	122,595	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	_____			43
44	_____			44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 122,595	\$ 122,595	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 317,967	\$ 317,967	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (361,968)	\$ (359,331)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ (44,001)	\$ (41,364)	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(373,757)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Rounding</b>	<b>(1)</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>(373,758)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>11,790</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>11,790</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>(361,968)</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	\$ 978,048	1
2	Discounts and Allowances for all Levels	(3,338)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 974,710	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,422	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 3,422	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	928	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 928	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Miscellaneous Revenue	252	28
28a	Meals on Wheels Revenue	4,016	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 4,268	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 983,328	30

2

Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	260,088	31
32	Health Care	459,590	32
33	General Administration	195,335	33
<b>B. Capital Expense</b>			
34	Ownership	36,314	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	994	35
36	Provider Participation Fee	19,217	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 971,538	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	11,790	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 11,790	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 Cisne Rehabilitation & Health Care Center

# 0047423

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	2,081	2,081	\$ 43,404	\$ 20.86	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,663	4,844	91,912	18.97	3
4	Licensed Practical Nurses	4,578	4,902	73,868	15.07	4
5	CNAs & Orderlies	19,232	19,603	169,065	8.62	5
6	CNA Trainees					6
7	Licensed Therapist	225	227	6,265	27.60	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,080	2,080	20,757	9.98	9
10	Activity Assistants					10
11	Social Service Workers	2,080	2,080	20,057	9.64	11
12	Dietician					12
13	Food Service Supervisor	2,167	2,167	22,536	10.40	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,174	7,269	55,957	7.70	15
16	Dishwashers					16
17	Maintenance Workers	20	20	156	7.80	17
18	Housekeepers	3,814	4,046	31,486	7.78	18
19	Laundry	1,870	1,968	15,494	7.87	19
20	Administrator	2,080	2,080	34,604	16.64	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					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>Transportation</u>	40	40	325	8.13	33
34	TOTAL (lines 1 - 33)	52,104	53,407	\$ 585,886 *	\$ 10.97	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 8,400	9(3)	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 600	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)	\$ 9,000		49

C. CONTRACT NURSES

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

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
<u>Pamela Mix-Bissey</u>	<u>Administrator</u>	<u>0</u>	\$ <u>34,604</u>	<u>Workers' Compensation Insurance</u>	\$ <u>9,099</u>	<u>IDPH License Fee</u>	\$ <u>995</u>	
				<u>Unemployment Compensation Insurance</u>	<u>21,856</u>	<u>Advertising: Employee Recruitment</u>	<u>114</u>	
				<u>FICA Taxes</u>	<u>43,849</u>	<u>Health Care Worker Background Check</u>		
				<u>Employee Health Insurance</u>	<u>1,154</u>	(Indicate # of checks performed )		
				<u>Employee Meals</u>		<u>Patient Background Checks</u>	<u>70</u>	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Miscellaneous Licenses &amp; Permits</u>	<u>150</u>	
				<u>Employee Relations</u>	<u>855</u>	<u>Miscellaneous Dues &amp; Subscriptions</u>	<u>30</u>	
				<u>Employee Retirement</u>	<u>1,209</u>	<u>IHCA Dues</u>	<u>820</u>	
<b>TOTAL (agree to Schedule V, line 17, col. 1)</b>			<b>\$ <u>34,604</u></b>			<u>Home Office Allocation</u>	<u>529</u>	
<b>(List each licensed administrator separately.)</b>								
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
			\$ <u>49,000</u>	\$ <u>78,022</u>			\$ <u>3,338</u>	
<b>Management Fees-See Page 6, Eliminated on P 3, C 7</b>				<b>(Attach a copy of any management service agreement)</b>				
				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services								
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
<u>Wabash Independent Networks</u>	<u>Computer Services</u>		\$ <u>2,921</u>				<u>Out-of-State Travel</u>	\$
<u>E-Health Data Solutions</u>	<u>Computer Services</u>		<u>2,700</u>					
<u>LTC Solutions</u>	<u>Computer Services</u>		<u>1,600</u>				<u>In-State Travel</u>	
				<u>N/A</u>				
							<u>Seminar Expense</u>	<u>70</u>
							<u>Home Office Allocation</u>	<u>118</u>
							<u>Entertainment Expense</u>	( )
<b>TOTAL (agree to Schedule V, line 19, column 3)</b>			<b>\$ <u>7,221</u></b>	<b>TOTAL</b>			<b>(agree to Sch. V, line 24, col. 8)</b>	
<b>(If total legal fees exceed \$5,000, attach copy of invoices.)</b>				\$			<b>\$ <u>188</u></b>	

\* Attach copy of IMRF notifications

\*\*See instructions.

**Cisne Rehabilitation & Health Care Center**

**0047423**

**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)		7,221

**Home Office Allocation**

Heyl, Royster, Voelker & Allen	Legal	119
GoffWilson, P.A.	Legal	198
Ginoli & Company	Accountants	1,659
RSM McGladrey	Accountants	5
Miscellaneous Vendors	Computer Services	23
Emdeon Business Services	Computer Services	32
Advanced Answers on Demand	Computer Services	375
Access 2 Go	Computer Services	111
Ivans	Computer Services	257
Kemper Technology	Computer Services	203
VisionShare	Computer Services	22
Logmein	Computer Services	16
Comm Net Communiations	Computer Services	6
Charter Communications	Computer Services	5
Advanced System Designs	Computer Services	7
Consolidated Communications	Computer Services	4
Miscellaneous Vendors	Miscellaneous	56

Total (agree to Schedule V, line 19, column 8)		<u>10,319</u>
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Facility Name & ID Number Cisne Rehabilitation & Health Care Center# 0047423Report 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. 820 -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. \$ 4,428 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. \$ 19,217  
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. \$ 4,944
- (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