



Facility Name & ID Number Collinsville Rehabilitation & Health Care Center

# 0048447 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	100	Skilled (SNF)	100	36,500	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	100	TOTALS	100	36,500	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF	16,248	2,037	1,807	20,092	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,248	2,037	1,807	20,092	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 55.05%

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 07/25/2006

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

YES

Date 07/25/2006

NO

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

YES

NO

If YES, enter number of beds certified 11 and days of care provided 1,807

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL

MODIFIED

CASH\*

CASH\*

Is your fiscal year identical to your tax year?

YES  NO

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

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

Facility Name & ID Number Collinsville Rehabilitation & Health Care Ctr # 0048447 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	112,292	11,266		123,558		123,558	3,571	127,129		1
2	Food Purchase		99,602		99,602		99,602	59	99,661		2
3	Housekeeping	80,938	15,533		96,471		96,471	26	96,497		3
4	Laundry	24,317	9,771		34,088		34,088	2	34,090		4
5	Heat and Other Utilities			81,101	81,101		81,101	370	81,471		5
6	Maintenance	25,943	10,835	25,986	62,764		62,764	2,305	65,069		6
7	Other (specify):* <u>Home Off. Ben. All.</u>							878	878		7
8	<b>TOTAL General Services</b>	243,490	147,007	107,087	497,584		497,584	7,211	504,795		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			5,400	5,400		5,400		5,400		9
10	Nursing and Medical Records	813,019	50,806	9,522	873,347		873,347	5,966	879,313		10
10a	Therapy			205,192	205,192		205,192		205,192		10a
11	Activities	19,406	984	1,303	21,693		21,693		21,693		11
12	Social Services	20,423	44		20,467		20,467		20,467		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Off. Ben. All.</u>							1,082	1,082		15
16	<b>TOTAL Health Care and Programs</b>	852,848	51,834	221,417	1,126,099		1,126,099	7,048	1,133,147		16
	<b>C. General Administration</b>										
17	Administrative	55,523		147,000	202,523		202,523	(119,199)	83,324		17
18	Directors Fees										18
19	Professional Services			12,433	12,433		12,433	7,928	20,361		19
20	Dues, Fees, Subscriptions & Promotions			12,928	12,928		12,928	1,058	13,986		20
21	Clerical & General Office Expenses	28,226	4,856	10,418	43,500		43,500	38,827	82,327		21
22	Employee Benefits & Payroll Taxes			168,866	168,866		168,866	6,752	175,618		22
23	Inservice Training & Education			88	88		88	212	300		23
24	Travel and Seminar							212	212		24
25	Other Admin. Staff Transportation			5,521	5,521		5,521	2,810	8,331		25
26	Insurance-Prop.Liab.Malpractice			15,537	15,537		15,537	167	15,704		26
27	Other (specify):* <u>Home Off. Ben. All.</u>							9,932	9,932		27
28	<b>TOTAL General Administration</b>	83,749	4,856	372,791	461,396		461,396	(51,301)	410,095		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,180,087	203,697	701,295	2,085,079		2,085,079	(37,042)	2,048,037		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

Collinsville Rehabilitation &amp; Health Care Center

#0048447

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			95,946	95,946		95,946	(14,349)	81,597			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			171,175	171,175		171,175	17,012	188,187			32
33	Real Estate Taxes			68,053	68,053		68,053	510	68,563			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			7,903	7,903		7,903	435	8,338			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			343,077	343,077		343,077	3,608	346,685			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		35,637		35,637		35,637		35,637			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,900	54,900		54,900		54,900			42
43	Other (specify):* Non-allowable Cost	31,253	245	94,112	125,610		125,610	(125,610)				43
44	<b>TOTAL Special Cost Centers</b>	31,253	35,882	149,012	216,147		216,147	(125,610)	90,537			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,211,340	239,579	1,193,384	2,644,303		2,644,303	(159,044)	2,485,259			45

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

**VI. ADJUSTMENT DETAIL**

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(1,269)	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	(19,927)	30		9
10	Interest and Other Investment Income	(7)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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	(13,879)	43		18
19	Entertainment				19
20	Contributions	(156)	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	(69,954)	43		24
25	Fund Raising, Advertising and Promotional	(35,669)	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	(5,430)	Various		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (146,291)		\$	30

BHF USE ONLY							
48		49		50		51	
							52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(12,753)	Various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (12,753)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (159,044)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

Collinsville Rehabilitation & Health Care Center

ID# 0048447

Report Period Beginning: 1/1/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (2,936)	43	1
2	X-Rays-Part A	(1,015)	43	2
3	Offset Miscellaneous Nursing Supplies Revenue	(232)	10	3
4	Resident Flower	(682)	43	4
5	Offset Miscellaneous Office Supplies Revenue	(515)	21	5
6	Disallowed Special Events	(50)	43	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(5,430)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Collinsville Rehabilitation & Health Care Center# 0048447

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	3,571	0	0	0	0	0	0	0	0	0	3,571	1
2	Food Purchase	0	59	0	0	0	0	0	0	0	0	0	59	2
3	Housekeeping	0	26	0	0	0	0	0	0	0	0	0	26	3
4	Laundry	0	2	0	0	0	0	0	0	0	0	0	2	4
5	Heat and Other Utilities	0	370	0	0	0	0	0	0	0	0	0	370	5
6	Maintenance	0	2,182	0	123	0	0	0	0	0	0	0	2,305	6
7	Other (specify):*	0	878	0	0	0	0	0	0	0	0	0	878	7
8	<b>TOTAL General Services</b>	0	7,088	0	123	0	0	0	0	0	0	0	7,211	8
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(232)	6,198	0	0	0	0	0	0	0	0	0	5,966	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	1,082	0	0	0	0	0	0	0	0	0	1,082	15
16	<b>TOTAL Health Care and Programs</b>	(232)	7,280	0	0	0	0	0	0	0	0	0	7,048	16
	<b>C. General Administration</b>													
17	Administrative	0	(119,199)	0	0	0	0	0	0	0	0	0	(119,199)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	3,138	0	4,790	0	0	0	0	0	0	0	7,928	19
20	Fees, Subscriptions & Promotions	0	0	968	90	0	0	0	0	0	0	0	1,058	20
21	Clerical & General Office Expenses	(515)	0	34,888	4,454	0	0	0	0	0	0	0	38,827	21
22	Employee Benefits & Payroll Taxes	0	0	0	6,752	0	0	0	0	0	0	0	6,752	22
23	Inservice Training & Education	0	0	212	0	0	0	0	0	0	0	0	212	23
24	Travel and Seminar	0	0	212	0	0	0	0	0	0	0	0	212	24
25	Other Admin. Staff Transportation	0	0	2,747	63	0	0	0	0	0	0	0	2,810	25
26	Insurance-Prop.Liab.Malpractice	0	0	167	0	0	0	0	0	0	0	0	167	26
27	Other (specify):*	0	0	9,932	0	0	0	0	0	0	0	0	9,932	27
28	<b>TOTAL General Administration</b>	(515)	(116,061)	49,126	16,149	0	0	0	0	0	0	0	(51,301)	28
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	(747)	(101,693)	49,126	16,272	0	0	0	0	0	0	0	(37,042)	29

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Collinsville Rehabilitation & Health Care Center# 0048447

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(19,927)	0	3,801	1,777	0	0	0	0	0	0	0	(14,349)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(7)	0	2,674	14,345	0	0	0	0	0	0	0	17,012	32
33	Real Estate Taxes	0	0	510	0	0	0	0	0	0	0	0	510	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	435	0	0	0	0	0	0	0	0	435	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(19,934)</b>	<b>0</b>	<b>7,420</b>	<b>16,122</b>	<b>0</b>	<b>3,608</b>	<b>37</b>						
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(125,610)	0	0	0	0	0	0	0	0	0	0	(125,610)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(125,610)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(125,610)</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(146,291)</b>	<b>(101,693)</b>	<b>56,546</b>	<b>32,394</b>	<b>0</b>	<b>(159,044)</b>	<b>45</b>						

**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	65	See Attached Schedule 6E		See Attached Sch 6E		
Jifi Jacob	10					
Cindy White	10					
Jacque Whitley	10					
David Petersen	5					

**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.	65.00%	\$ 3,571	\$ 3,571	1
2	V	2 Food		Petersen Health Care, Inc.	65.00%	59	59	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	65.00%	26	26	3
4	V	4 Laundry		Petersen Health Care, Inc.	65.00%	2	2	4
5	V	5 Utilities		Petersen Health Care, Inc.	65.00%	370	370	5
6	V	6 Maintenance		Petersen Health Care, Inc.	65.00%	2,182	2,182	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	65.00%	878	878	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	65.00%	6,198	6,198	8
9	V	11 Activities		Petersen Health Care, Inc.	65.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	65.00%	1,082	1,082	10
11	V	17 Administrative	147,000	Petersen Health Care, Inc.	65.00%	27,801	(119,199)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	65.00%	3,138	3,138	12
13	V							13
14	Total		\$ 147,000			\$ 45,307	\$ * (101,693)	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.	65.00%	\$ 968	\$	968	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	65.00%	34,888		34,888	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	65.00%	212		212	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	65.00%	212		212	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	65.00%	2,747		2,747	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	65.00%	167		167	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	65.00%	9,932		9,932	21
22	V	30 Depreciation		Petersen Health Care, Inc.	65.00%	3,801		3,801	22
23	V	32 Interest		Petersen Health Care, Inc.	65.00%	2,674		2,674	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	65.00%	510		510	24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	65.00%	0			25
26	V	35 Rent-Equipment and Vehicles		Petersen Health Care, Inc.	65.00%	435		435	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		\$			\$ 56,546	\$ *	56,546	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 Enterprises, LLC	100.00%	\$ 0	\$	15	
16	V	2 Food		Petersen Health Enterprises, LLC	100.00%	0		16	
17	V	3 Housekeeping		Petersen Health Enterprises, LLC	100.00%	0		17	
18	V	4 Laundry		Petersen Health Enterprises, LLC	100.00%	0		18	
19	V	5 Utilities		Petersen Health Enterprises, LLC	100.00%	0		19	
20	V	6 Maintenance		Petersen Health Enterprises, LLC	100.00%	123	123	20	
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Enterprises, LLC	100.00%	0		21	
22	V	10 Nursing and Medical Records		Petersen Health Enterprises, LLC	100.00%	0		22	
23	V	15 Mgmt. Allocation of Benefits		Petersen Health Enterprises, LLC	100.00%	0		23	
24	V	17 Administrative		Petersen Health Enterprises, LLC	100.00%	0		24	
25	V	19 Professional Services		Petersen Health Enterprises, LLC	100.00%	4,790	4,790	25	
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Enterprises, LLC	100.00%	90	90	26	
27	V	21 Clerical and General Office		Petersen Health Enterprises, LLC	100.00%	4,454	4,454	27	
28	V	22 Employee Benefits & Payroll		Petersen Health Enterprises, LLC	100.00%	6,752	6,752	28	
29	V	23 Inservice Training & Education		Petersen Health Enterprises, LLC	100.00%	0		29	
30	V	24 Travel and Seminar		Petersen Health Enterprises, LLC	100.00%	0		30	
31	V	25 Other Admin. Staff Transport.		Petersen Health Enterprises, LLC	100.00%	63	63	31	
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Enterprises, LLC	100.00%	0		32	
33	V	27 Mgmt. Allocation of Benefits		Petersen Health Enterprises, LLC	100.00%	0		33	
34	V	30 Depreciation		Petersen Health Enterprises, LLC	100.00%	1,777	1,777	34	
35	V	32 Interest		Petersen Health Enterprises, LLC	100.00%	14,345	14,345	35	
36	V	33 Real Estate Taxes		Petersen Health Enterprises, LLC	100.00%	0		36	
37	V	34 Rent-Facility and Grounds		Petersen Health Enterprises, LLC	100.00%	0		37	
38	V	35 Rent-Equipment & Vehicles		Petersen Health Enterprises, LLC	100.00%	0		38	
39	<b>Total</b>		\$			\$ 32,394	\$ *	32,394	39

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

Facility Name & ID Number Collinsville Rehabilitation & Health Care Ce # 0048447 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	70.00	1,800,873	0.83	1.39	Salary	27,801	L17, C7	1
2	Jifi Jacob	Owner	Administrative	10.00						L21, C7	2
3	Cindy S. White	Owner	Administrative	10.00	105,038	0.85	1.42	Salary	1,621	L21, C7	3
4	Jacque Whitley	Owner	Administrative	10.00	94,141	0.85	1.42	Salary	1,453	L10, C7	4
5	David Petersen	Owner	Administrative	5.00							5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 30,875		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 Collinsville Rehabilitation & Health Care Center

# 0048447

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	20,092	\$ 3,571	1
2	2	Food	Resident Days	1,413,604	69	4,125	0	20,092	59	2
3	3	Housekeeping	Resident Days	1,413,604	69	1,859	0	20,092	26	3
4	4	Laundry	Resident Days	1,413,604	69	110	0	20,092	2	4
5	5	Utilities	Resident Days	1,413,604	69	26,036	0	20,092	370	5
6	6	Maintenance	Resident Days	1,413,604	69	153,551	100,245	20,092	2,182	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	61,774	0	20,092	878	7
8	10	Nursing and Medical Records	Resident Days	1,413,604	69	436,084	432,530	20,092	6,198	8
9	10A	Therapy	Resident Days	1,413,604	69	0	0	20,092	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	76,136	0	20,092	1,082	10
11	17	Administrative	Resident Days	1,413,604	69	1,955,999	1,956,000	20,092	27,801	11
12	19	Professional Services	Resident Days	1,413,604	69	220,762	0	20,092	3,138	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,413,604	69	68,094	0	20,092	968	13
14	21	Clerical and General Office	Resident Days	1,413,604	69	2,454,596	2,013,896	20,092	34,888	14
15	23	Inservice Training & Education	Resident Days	1,413,604	69	14,912	0	20,092	212	15
16	24	Travel and Seminar	Resident Days	1,413,604	69	14,938	0	20,092	212	16
17	25	Other Admin. Staff Transport.	Resident Days	1,413,604	69	193,264	0	20,092	2,747	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,413,604	69	11,767	0	20,092	167	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	698,810	0	20,092	9,932	19
20	30	Depreciation	Resident Days	1,413,604	69	267,426	0	20,092	3,801	20
21	32	Interest	Resident Days	1,413,604	69	188,107	0	20,092	2,674	21
22	33	Real Estate Taxes	Resident Days	1,413,604	69	35,872	0	20,092	510	22
23	34	Rent-Facility and Grounds	Resident Days	1,413,604	69	0	0	20,092	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,413,604	69	30,580	0	20,092	435	24
25	TOTALS					\$ 7,166,062	\$ 4,753,358		\$ 101,853	25

Facility Name & ID Number Collinsville Rehabilitation & Health Care Center

# 0048447

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 Enterprises, 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	95,327	5	\$	20,092	\$	1
2	2	Food	Resident Days	95,327	5		20,092		2
3	3	Housekeeping	Resident Days	95,327	5		20,092		3
4	4	Laundry	Resident Days	95,327	5		20,092		4
5	5	Utilities	Resident Days	95,327	5		20,092		5
6	6	Maintenance	Resident Days	95,327	5	585	20,092	123	6
7	7	Mgmt. Allocation of Benefits	Resident Days	95,327	5		20,092		7
8	10	Nursing and Medical Records	Resident Days	95,327	5		20,092		8
9	15	Mgmt. Allocation of Benefits	Resident Days	95,327	5		20,092		9
10	17	Administrative	Resident Days	95,327	5		20,092		10
11	19	Professional Services	Resident Days	95,327	5	22,726	20,092	4,790	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	95,327	5	427	20,092	90	12
13	21	Clerical and General Office	Resident Days	95,327	5	21,132	20,092	4,454	13
14	22	Employee Benefits & Payroll	Resident Days	95,327	5	32,035	20,092	6,752	14
15	23	Inservice Training & Education	Resident Days	95,327	5		20,092		15
16	24	Travel and Seminar	Resident Days	95,327	5		20,092		16
17	25	Other Admin. Staff Transport.	Resident Days	95,327	5	301	20,092	63	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	95,327	5		20,092		18
19	27	Mgmt. Allocation of Benefits	Resident Days	95,327	5		20,092		19
20	30	Depreciation	Resident Days	95,327	5	8,430	20,092	1,777	20
21	32	Interest	Resident Days	95,327	5	68,058	20,092	14,345	21
22	33	Real Estate Taxes	Resident Days	95,327	5		20,092		22
23	34	Rent-Facility and Grounds	Resident Days	95,327	5		20,092		23
24	35	Rent-Equipment & Vehicles	Resident Days	95,327	5		20,092		24
25	TOTALS					\$ 153,694	\$	\$ 32,394	25



**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>65,000</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>65,053</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	53	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>68,000</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>510</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>68,563</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	8
	2004	9
	2005	10
	2006	<b>62,716</b> 11
	2007	<b>65,053</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 Collinsville Rehabilitation & Health Care Center COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0048447

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>13-2-21-28-18-303-001</u>	<u>Long-Term Care Facility</u>	\$ <u>65,053.22</u>	\$ <u>65,053.22</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>65,053.22</u>	\$ <u>65,053.22</u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?        YES   X   NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the original 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

**PLEASE NOTE:** Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 29,350 B. General Construction Type: Exterior Brick Frame Steel 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

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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>391,343</u>	<u>2006</u>	<u>\$ 40,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>391,343</b>		<b>\$ 40,000</b>	<b>3</b>

Facility Name & ID Number Collinsville Rehabilitation & Health Care Center

# 0048447

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	100	2006	1962	\$ 1,635,299	\$	30	\$ 54,510	\$ 54,510	\$ 136,275
5									
6									
7	Home Office Allocation								
8									
<b>Improvement Type**</b>									
9	Wheelchair Ramp		2007	2,530		15	169	169	253
10	Fountain		2007	1,269		15	85	85	127
11	Exit Signs		2007	612		7	87	87	131
12	Blinds		2007	4,886		10	489	489	733
13	Exit Signs		2008	690		15	23	23	23
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
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			65,634			(65,634)		40
41			383			(383)		41
42								42
43								43
44		698			45	45		44
45		10,432			250	250		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		\$ 1,656,416	\$ 66,017		\$ 55,658	\$ (10,359)	\$ 137,542	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	\$ 197,327	\$ 29,271	\$ 19,733	\$ (9,538)	10 yrs.	\$ 48,202	71
72	Current Year Purchases	12,567	658	628	(30)	10 yrs.	628	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			5,578	5,578			74
75	TOTALS	\$ 209,894	\$ 29,929	\$ 25,939	\$ (3,990)		\$ 48,830	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)	\$ 1,906,310	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 95,946	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 81,597	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (14,349)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 186,372	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	<b>TOTAL</b>				\$ _____			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: \$ 8,338 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	<b>TOTAL</b>		\$ _____	\$ _____	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.

**Collinsville Rehabilitation & Health Care Center**

**0048447**

**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	\$ 4,267
Dishwasher	708
Laundry Equipment	36
Copier	2,892
Home Office Allocation	435
	<u>8,338</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	\$	5,037	\$ 75,549	\$	5,037	\$ 75,549	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2,696	40,444		2,696	40,444	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		5,939	89,089		5,939	89,089	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 prescrpts				35,637		35,637	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): <u>Respiratory Therapy</u>				7	110		7	110	13
14	<b>TOTAL</b>			\$	13,679	\$ 205,192	\$ 35,637	13,679	\$ 240,829	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**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ (232,055)	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<u>Rounding</u>	(1)	<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>	\$ (232,056)	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(130,786)	<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>	\$ (130,786)	<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>	\$ (362,842)	<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	\$ 1,998,773	1
2	Discounts and Allowances for all Levels	139,396	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,138,169	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	304,775	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 304,775	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		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	63,416	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	4,293	20
21	Other Medical Services	2,110	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 69,819	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	7	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 7	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Miscellaneous Revenue</u>	747	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 747	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,513,517	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	497,584	31
32	Health Care	1,126,099	32
33	General Administration	461,396	33
	<b>B. Capital Expense</b>		
34	Ownership	343,077	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	161,247	35
36	Provider Participation Fee	54,900	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,644,303	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(130,786)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (130,786)	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 Collinsville Rehabilitation & Health Care Center

# 0048447

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	1,703	1,703	\$ 44,915	\$ 26.37	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,540	4,572	109,932	24.04	3
4	Licensed Practical Nurses	11,662	11,878	239,136	20.13	4
5	CNAs & Orderlies	37,200	38,189	372,548	9.76	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,232	1,289	14,841	11.51	9
10	Activity Assistants	537	537	4,565	8.50	10
11	Social Service Workers	1,747	1,747	20,423	11.69	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	29,454	14.16	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,069	10,330	82,838	8.02	15
16	Dishwashers					16
17	Maintenance Workers	1,859	1,884	25,943	13.77	17
18	Housekeepers	9,249	9,430	80,938	8.58	18
19	Laundry	2,997	3,036	24,317	8.01	19
20	Administrator	2,040	2,040	55,523	27.22	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,178	2,218	28,226	12.73	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	135	135	1,051	7.79	31
32	Other Health C: Care Plan Coord.	2,080	2,080	45,437	21.84	32
33	Other(specify) <u>Marketing</u>	1,687	1,687	31,253	18.53	33
34	TOTAL (lines 1 - 33)	92,995	94,835	\$ 1,211,340 *	\$ 12.77	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	5,400	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,000	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)		\$ 6,400		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	9	\$ 313	10(3)	50
51	Licensed Practical Nurses	168	5,395	10(3)	51
52	Certified Nurse Assistants/Aides	61	1,202	10(3)	52
53	TOTAL (lines 50 - 52)	238	\$ 6,910		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		
Donna Weeks	Administrator	0	\$ 55,523	Workers' Compensation Insurance	\$ 45,609	IDPH License Fee	\$ 995		
				Unemployment Compensation Insurance	25,442	Advertising: Employee Recruitment	1,721		
				FICA Taxes	88,666	Health Care Worker Background Check (Indicate # of checks performed )			
				Employee Health Insurance	8,332	Patient Background Checks	26		
				Employee Meals		Miscellaneous Licenses & Permits	650		
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Dues & Subscriptions	0		
				Employee Relations	7,569	IHCA Dues	7,230		
						Home Office Allocation	1,058		
						CMS Revisit Fee	2,072		
						Less: Public Relations Expense	( )		
						Non-allowable advertising	( )		
						Yellow page advertising	( )		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 55,523	TOTAL (agree to Schedule V, line 22, col.8)		\$ 175,618	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 13,986
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	
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 147,000				Out-of-State Travel	\$	
							In-State Travel		
							Seminar Expense		
							Home Office Allocation	212	
							Entertainment Expense	( )	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 147,000				TOTAL (agree to Sch. V, line 24, col. 8)		\$ 212
C. Professional Services									
Vendor/Payee	Type		Amount						
E-Health Data Solutions	Computer Services		\$ 3,375						
Mutual of Omaha	Computer Services		4						
Linden Engineering	Accounting Services		3,386						
Heyl, Royster, Voelker & Allen	Legal Services		4,068						
LTC Solutions	Computer Services		1,600						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 12,433	TOTAL		\$			

\* Attach copy of IMRF notifications

\*\*See instructions.

**Collinsville Rehabilitation & Health Care Center****0048447****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)		12,433

**Home Office Allocation**

Heyl, Royster, Voelker & Allen	Legal	114
GoffWilson, P.A.	Legal	381
Ginoli & Company	Accountants	5,715
RSM McGladrey	Accountants	9
Miscellaneous Vendors	Computer Services	44
Emdeon Business Services	Computer Services	61
Advanced Answers on Demand	Computer Services	721
Access 2 Go	Computer Services	213
Ivans	Computer Services	110
Kemper Technology	Computer Services	390
VisionShare	Computer Services	42
Logmein	Computer Services	30
Comm Net Communiations	Computer Services	11
Charter Communications	Computer Services	9
Advanced System Designs	Computer Services	14
Consolidated Communications	Computer Services	8
Miscellaneous Vendors	Miscellaneous	56

Total (agree to Schedule V, line 19, column 8)	<u>20,361</u>
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**Collinsville Rehabilitation & Health Care Center**

**0048447**

**Period Beginning 1/1/2008**

**Period End 12/31/2008**

**XIX. SUPPORT SCHEDULES**

**Schedule 21B**

**A. Administrative Salaries**

<b>Name</b>	<b>Function</b>	<b>Ownership %</b>	<b>Amount</b>
Donna Weeks	Administrator	0	55,523
		<b>Total</b>	<u>55,523</u>



Facility Name & ID Number Collinsville Rehabilitation & Health Care Center# 0048447Report 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. 7,230 -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. \$ 11,436 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. \$ 54,900  
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? No Indicate the amount. \$ 0
- (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