

Facility Name & ID Number Decatur Rehabilitation & Health Care Center

0047449 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	58	Intermediate (ICF)	58	21,228	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	58	TOTALS	58	21,228	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	14,641	646	469	15,756	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,641	646	469	15,756	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.22%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

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

YES

NO

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

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

YES

NO

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

Date started 10/1/05

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

YES

Date 10/1/05

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 Decatur Rehabilitation & Health Care Center # 0047449 Report Period Beginning: 1/1/2008 Ending: 12/31/2008

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	87,539	7,790		95,329		95,329	2,801	98,130		1
2	Food Purchase		88,615		88,615		88,615	(325)	88,290		2
3	Housekeeping	80,600	16,542		97,142		97,142	21	97,163		3
4	Laundry	17,126	10,623		27,749		27,749	1	27,750		4
5	Heat and Other Utilities			46,198	46,198		46,198	290	46,488		5
6	Maintenance	29,597	9,660	31,485	70,742		70,742	2,571	73,313		6
7	Other (specify):* <u>Home Off. Ben. All.</u>							954	954		7
8	TOTAL General Services	214,862	133,230	77,683	425,775		425,775	6,313	432,088		8
	B. Health Care and Programs										
9	Medical Director			17,500	17,500		17,500		17,500		9
10	Nursing and Medical Records	490,619	33,642	28,602	552,863		552,863	4,693	557,556		10
10a	Therapy		7		7		7		7		10a
11	Activities	24,882	968	973	26,823		26,823		26,823		11
12	Social Services	25,383	52		25,435		25,435	7	25,442		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Off. Ben. All.</u>							849	849		15
16	TOTAL Health Care and Programs	540,884	34,669	47,075	622,628		622,628	5,549	628,177		16
	C. General Administration										
17	Administrative	66,152		71,000	137,152		137,152	(47,488)	89,664		17
18	Directors Fees										18
19	Professional Services			5,315	5,315		5,315	4,668	9,983		19
20	Dues, Fees, Subscriptions & Promotions			5,455	5,455		5,455	91	5,546		20
21	Clerical & General Office Expenses	20,659	4,326	8,394	33,379		33,379	30,665	64,044		21
22	Employee Benefits & Payroll Taxes			105,672	105,672		105,672		105,672		22
23	Inservice Training & Education			88	88		88	177	265		23
24	Travel and Seminar			202	202		202	177	379		24
25	Other Admin. Staff Transportation			7,075	7,075		7,075	6,135	13,210		25
26	Insurance-Prop.Liab.Malpractice			11,277	11,277		11,277	131	11,408		26
27	Other (specify):* <u>Home Off. Ben. All.</u>							8,997	8,997		27
28	TOTAL General Administration	86,811	4,326	214,478	305,615		305,615	3,553	309,168		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	842,557	172,225	339,236	1,354,018		1,354,018	15,415	1,369,433		29

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

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

Facility Name & ID Number

Decatur Rehabilitation & Health Care Center

#0047449

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			25,934	25,934		25,934	2,675	28,609			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			21,090	21,090		21,090	10,075	31,165			32
33	Real Estate Taxes			23,944	23,944		23,944	400	24,344			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			3,955	3,955		3,955	341	4,296			35
36	Other (specify):*											36
37	TOTAL Ownership			74,923	74,923		74,923	13,491	88,414			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		19,206		19,206		19,206		19,206			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			31,842	31,842		31,842		31,842			42
43	Other (specify):* Non-allowable Cost		949	16,042	16,991		16,991	(16,991)				43
44	TOTAL Special Cost Centers		20,155	47,884	68,039		68,039	(16,991)	51,048			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	842,557	192,380	462,043	1,496,980		1,496,980	11,915	1,508,895			45

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

Decatur Rehabilitation & Health Care Center

ID# 0047449

Report Period Beginning: 1/1/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (306)	43	1
2	Resident Flowers	(318)	43	2
3	Offset Miscellaneous Nursing Supplies Revenue	(168)	10	3
4	Offset Miscellaneous Food Revenue	(374)	2	4
5	Offset Miscellaneous Office Supplies Revenue	(926)	21	5
6	Offset Chamber of Commerce Dues	(705)	20	6
7	Pet Expense	(9)	43	7
8	Disallowed Special Events	(259)	43	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
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22				22
23				23
24				24
25				25
26				26
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32				32
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39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(3,065)		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%	\$ 2,801	\$ 2,801	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	46	46	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	21	21	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	1	1	4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	290	290	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	1,711	1,711	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	689	689	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	4,861	4,861	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%	849	849	10
11	V	17 Administrative	71,000	Petersen Health Care, Inc.	100.00%	21,802	(49,198)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	2,461	2,461	12
13	V							13
14	Total		\$ 71,000			\$ 35,532	\$ * (35,468)	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%	\$ 759	\$	759	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	27,359		27,359	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	166		166	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	166		166	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	2,154		2,154	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	131		131	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	7,789		7,789	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	2,981		2,981	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	2,097		2,097	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	400		400	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%	341		341	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		\$			\$ 44,343	\$ *	44,343	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%	3	3	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%	860	860	20	
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	265	265	21	
22	V	10 Nursing and Medical Records		Petersen Health Operations, LLC	100.00%	0		22	
23	V	12 Social Services		Petersen Health Operations, LLC	100.00%	7	7	23	
24	V	17 Administrative		Petersen Health Operations, LLC	100.00%	1,710	1,710	24	
25	V	19 Professional Services		Petersen Health Operations, LLC	100.00%	2,207	2,207	25	
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Operations, LLC	100.00%	37	37	26	
27	V	21 Clerical and General Office		Petersen Health Operations, LLC	100.00%	4,232	4,232	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%	11	11	29	
30	V	24 Travel and Seminar		Petersen Health Operations, LLC	100.00%	11	11	30	
31	V	25 Other Admin. Staff Transport.		Petersen Health Operations, LLC	100.00%	3,981	3,981	31	
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Operations, LLC	100.00%	0		32	
33	V	27 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	1,208	1,208	33	
34	V	30 Depreciation		Petersen Health Operations, LLC	100.00%	978	978	34	
35	V	32 Interest		Petersen Health Operations, LLC	100.00%	7,982	7,982	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		\$			\$ 23,492	\$ *	23,492	39

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

Facility Name & ID Number Decatur Rehabilitation & Health Care Cente # 0047449 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	1,806,872	0.65	1.09	Salary	21,802	L17, C7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 21,802		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 Decatur Rehabilitation & Health Care Center

0047449

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	15,756	\$ 2,801	1
2	2	Food	Resident Days	1,413,604	69	4,125	0	15,756	46	2
3	3	Housekeeping	Resident Days	1,413,604	69	1,859	0	15,756	21	3
4	4	Laundry	Resident Days	1,413,604	69	110	0	15,756	1	4
5	5	Utilities	Resident Days	1,413,604	69	26,036	0	15,756	290	5
6	6	Maintenance	Resident Days	1,413,604	69	153,551	100,245	15,756	1,711	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	61,774	0	15,756	689	7
8	10	Nursing and Medical Records	Resident Days	1,413,604	69	436,084	432,530	15,756	4,861	8
9	10A	Therapy	Resident Days	1,413,604	69	0	0	15,756	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	76,136	0	15,756	849	10
11	17	Administrative	Resident Days	1,413,604	69	1,955,999	1,956,000	15,756	21,802	11
12	19	Professional Services	Resident Days	1,413,604	69	220,762	0	15,756	2,461	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,413,604	69	68,094	0	15,756	759	13
14	21	Clerical and General Office	Resident Days	1,413,604	69	2,454,596	2,013,896	15,756	27,359	14
15	23	Inservice Training & Education	Resident Days	1,413,604	69	14,912	0	15,756	166	15
16	24	Travel and Seminar	Resident Days	1,413,604	69	14,938	0	15,756	166	16
17	25	Other Admin. Staff Transport.	Resident Days	1,413,604	69	193,264	0	15,756	2,154	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,413,604	69	11,767	0	15,756	131	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	698,810	0	15,756	7,789	19
20	30	Depreciation	Resident Days	1,413,604	69	267,426	0	15,756	2,981	20
21	32	Interest	Resident Days	1,413,604	69	188,107	0	15,756	2,097	21
22	33	Real Estate Taxes	Resident Days	1,413,604	69	35,872	0	15,756	400	22
23	34	Rent-Facility and Grounds	Resident Days	1,413,604	69	0	0	15,756	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,413,604	69	30,580	0	15,756	341	24
25	TOTALS					\$ 7,166,062	\$ 4,753,358		\$ 79,875	25

Facility Name & ID Number Decatur Rehabilitation & Health Care Center

0047449

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	\$	15,756	\$	1
2	2	Food	Resident Days	419,957	23	68	15,756	3	2
3	3	Housekeeping	Resident Days	419,957	23		15,756		3
4	4	Laundry	Resident Days	419,957	23		15,756		4
5	5	Utilities	Resident Days	419,957	23		15,756		5
6	6	Maintenance	Resident Days	419,957	23	22,929	10,000	860	6
7	7	Mgmt. Allocation of Benefits	Resident Days	419,957	23	7,067	15,756	265	7
8	10	Nursing and Medical Records	Resident Days	419,957	23	6	15,756		8
9	12	Social Services	Resident Days	419,957	23	187	15,756	7	9
10	17	Administrative	Resident Days	419,957	23	45,582	45,582	1,710	10
11	19	Professional Services	Resident Days	419,957	23	58,812	15,756	2,207	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	419,957	23	997	15,756	37	12
13	21	Clerical and General Office	Resident Days	419,957	23	112,798	15,756	4,232	13
14	22	Employee Benefits & Payroll	Resident Days	419,957	23		15,756		14
15	23	Inservice Training & Education	Resident Days	419,957	23	299	15,756	11	15
16	24	Travel and Seminar	Resident Days	419,957	23	296	15,756	11	16
17	25	Other Admin. Staff Transport.	Resident Days	419,957	23	106,105	15,756	3,981	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	419,957	23		15,756		18
19	27	Mgmt. Allocation of Benefits	Resident Days	419,957	23	32,211	15,756	1,208	19
20	30	Depreciation	Resident Days	419,957	23	26,070	15,756	978	20
21	32	Interest	Resident Days	419,957	23	212,765	15,756	7,982	21
22	33	Real Estate Taxes	Resident Days	419,957	23		15,756		22
23	34	Rent-Facility and Grounds	Resident Days	419,957	23		15,756		23
24	35	Rent-Equipment & Vehicles	Resident Days	419,957	23		15,756		24
25	TOTALS					\$ 626,192	\$ 55,582	\$ 23,492	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	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			
A. Directly Facility Related																				
Long-Term																				
1	Bank of America		X	Mortgage	Varies	1/19/2007	\$ 325,000	\$ 318,975	12/31/13	Varies	\$ 21,090	1								
2												2								
3							Interest Income Offset				(4)	3								
4							Home Office Allocation-PHC				2,097	4								
5							Home Office Allocation-PHO				7,982	5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related						\$ 325,000	\$ 318,975			\$ 31,165	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 325,000	\$ 318,975			\$ 31,165	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.		\$	23,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2007	\$	22,944	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(56)	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	24,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. Home Office Allocation			400	
TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	24,344	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003		8
	2004		9
	2005	27,708	10
	2006	21,521	11
	2007	22,944	12

Accrual based on prior year tax bill.

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2007	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2008 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Decatur Rehabilitation & Health Care Center COUNTY Macon

FACILITY IDPH LICENSE NUMBER 0047449

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>04-12-17-254-003</u>	<u>Long-Term Care Facility</u>	\$ <u>21,712.22</u>	\$ <u>21,712.22</u>
2. <u>04-12-17-254-004</u>	<u>Long-Term Care Facility</u>	\$ <u>1,232.08</u>	\$ <u>1,232.08</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>22,944.30</u>	\$ <u>22,944.30</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: 8,653 B. General Construction Type: Exterior Brick Frame Concrete 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>43,560</u>	<u>2005</u>	<u>\$ 37,500</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	43,560		\$ 37,500	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	58	2005	1970	\$ 275,500	\$	25	\$ 11,020	\$ 11,020	\$ 38,570
5									
6									
7									
8									
Improvement Type**									
9	Original Land Improvements		2005	10,000		15	667	667	2,334
10	Sidewalks		2006	2,311		15	154	154	385
11	Remodel Nurses Station		2007	6,718		15	448	448	672
12	Water Heater-100 Gallon		2008	5,604		5	560	560	560
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28	Building Booked				11,069			(11,069)	
29	Building Improvement Booked				1,743			(1,743)	
30									
31									
32	2008-Home Office Allocation-Land Improvements			547			35	35	
33	2008-Home Office Allocation-Building Improvements			8,181			196	196	
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)	\$ 308,861	\$ 12,812		\$ 13,080	\$ 268	\$ 42,521	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	\$ 85,060	\$ 12,227	\$ 11,175	\$ (1,052)	5-10 yrs.	\$ 37,339	71
72	Current Year Purchases	3,300	895	165	(730)	10 yrs.	165	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			4,189	4,189			74
75	TOTALS	\$ 88,360	\$ 13,122	\$ 15,529	\$ 2,407		\$ 37,504	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)	\$ 434,721	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 25,934	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 28,609	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,675	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 80,025	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	Non-Care Vacant Land	\$ 75,000	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 75,000	\$	\$	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? YES NO

If NO, see instructions.

		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: \$ 4,296 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			N/A		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.

Decatur Rehabilitation & Health Care Center

0047449

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	\$	756
Dishwasher		649
Laundry Equipment		59
Copier		2,491
Home Office Allocation		341
		<u>4,296</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	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$			\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2)	hrs				7		7	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				19,206		19,206	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____									13
14	TOTAL			\$		\$	19,213		\$ 19,213	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	
1	Balance at Beginning of Year, as Previously Reported	\$ 71,312	1
2	Restatements (describe):		2
3	Rounding	1	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 71,313	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	278,485	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 278,485	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 349,798	24 *

* This must agree with page 17, line 47.

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

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

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 1,773,993	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,773,993	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	374	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	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 374	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Revenue</u>	1,094	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,094	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,775,465	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	425,775	31
32	Health Care	622,628	32
33	General Administration	305,615	33
	B. Capital Expense		
34	Ownership	74,923	34
	C. Ancillary Expense		
35	Special Cost Centers	36,197	35
36	Provider Participation Fee	31,842	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,496,980	40
41	Income before Income Taxes (line 30 minus line 40)**	278,485	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 278,485	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 Decatur Rehabilitation & Health Care Center

0047449

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	1,504	1,504	\$ 35,262	\$ 23.45	1
2	Assistant Director of Nursing	528	592	11,644	19.67	2
3	Registered Nurses	1,731	1,959	42,254	21.57	3
4	Licensed Practical Nurses	7,763	7,899	146,463	18.54	4
5	CNAs & Orderlies	23,483	23,797	233,198	9.80	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,986	1,986	24,882	12.53	9
10	Activity Assistants					10
11	Social Service Workers	1,973	1,973	25,383	12.87	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	24,961	12.00	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,466	7,837	62,578	7.98	15
16	Dishwashers					16
17	Maintenance Workers	2,011	2,090	29,597	14.16	17
18	Housekeepers	8,515	8,941	80,600	9.01	18
19	Laundry	2,136	2,215	17,126	7.73	19
20	Administrator	2,080	2,080	66,152	31.80	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,905	1,983	20,659	10.42	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	36	36	369	10.25	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Care Plan Coord.</u>	998	1,062	21,429	20.18	33
34	TOTAL (lines 1 - 33)	66,195	68,034	\$ 842,557 *	\$ 12.38	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$		35
36	Medical Director	Monthly 17,500	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)	\$ 18,100		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	684 27,779	10(3)	51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)	684 \$ 27,779		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	
Lynnette Green	Administrator	0	\$ 66,152	Workers' Compensation Insurance	\$ 15,220	IDPH License Fee	\$	
				Unemployment Compensation Insurance	31,143	Advertising: Employee Recruitment	1,469	
				FICA Taxes	63,574	Health Care Worker Background Check		
				Employee Health Insurance	(5,465)	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks	133 1,331	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	690	
				Employee Relations	1,200	Miscellaneous Dues & Subscriptions	705	
TOTAL (agree to Schedule V, line 17, col. 1)						IHCA Dues	1,260	
(List each licensed administrator separately.)			\$ 66,152			Home Office Allocation	796	
B. Administrative - Other								
Description			Amount			Less: Public Relations Expense	(705)	
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 71,000			Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 71,000	TOTAL (agree to Schedule V, line 22, col.8)	\$ 105,672	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 5,546	
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description			Description	
Vendor/Payee	Type		Amount		Line #	Amount	Amount	
AT&T	Computer Services		\$ 1,015				Out-of-State Travel	\$
E-Health Data Solutions	Computer Services		2,700					
LTC Solutions	Computer Services		1,600				In-State Travel	
				N/A				
							Seminar Expense	202
							Home Office Allocation	177
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL	\$		(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 5,315				TOTAL	\$ 379

* Attach copy of IMRF notifications

**See instructions.

Decatur Rehabilitation & Health Care Center

0047449

Period Beginning 1/1/2008

Period End 12/31/2008

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		5,315

Home Office Allocation

Heyl, Royster, Voelker & Allen	Legal	179
GoffWilson, P.A.	Legal	299
Ginoli & Company	Accountants	2,500
RSM McGladrey	Accountants	7
Miscellaneous Vendors	Computer Services	35
Emdeon Business Services	Computer Services	48
Advanced Answers on Demand	Computer Services	565
Access 2 Go	Computer Services	167
Ivans	Computer Services	387
Kemper Technology	Computer Services	306
VisionShare	Computer Services	33
Logmein	Computer Services	24
Comm Net Communiations	Computer Services	9
Charter Communications	Computer Services	7
Advanced System Designs	Computer Services	11
Consolidated Communications	Computer Services	7
Miscellaneous Vendors	Miscellaneous	84

Total (agree to Schedule V, line 19, column 8)		<u>9,983</u>
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Decatur Rehabilitation & Health Care Center

0047449

Period Beginning 1/1/2008

Period End 12/31/2008

XIX. SUPPORT SCHEDULES

Schedule 21B

A. Administrative Salaries

Name	Function	Ownership %	Amount
Lynette Green	Administrator	0	<u>66,152</u>
	Total		<u><u>66,152</u></u>

Facility Name & ID Number Decatur Rehabilitation & Health Care Center# 0047449Report Period Beginning: 1/1/2008Ending: 12/31/2008**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. 1,260 -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. \$ 4,632 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. \$ 31,842
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. \$ 374
- (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