

Facility Name & ID Number Effingham Rehabilitation & Health Care Center

0047159 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	<u>62</u>	Skilled (SNF)	<u>62</u>	<u>22,692</u>	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	<u>62</u>	TOTALS	<u>62</u>	<u>22,692</u>	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	<u>13,086</u>	<u>3,980</u>	<u>2,120</u>	<u>19,186</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>13,086</u>	<u>3,980</u>	<u>2,120</u>	<u>19,186</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.55%

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 05/01/05

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

YES

Date 05/01/05

NO

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

YES

NO

If YES, enter number of beds certified 16 and days of care provided 2,120

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL

MODIFIED

CASH*

CASH*

Is your fiscal year identical to your tax year?

YES NO

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

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

Facility Name & ID Number Effingham Rehabilitation & Health Care Cen # 0047159 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	110,613	9,341		119,954		119,954	3,410	123,364		1
2	Food Purchase		88,904		88,904		88,904	(378)	88,526		2
3	Housekeeping	33,585	10,770		44,355		44,355	25	44,380		3
4	Laundry	51,189	12,145		63,334		63,334	2	63,336		4
5	Heat and Other Utilities			79,338	79,338		79,338	353	79,691		5
6	Maintenance	26,643	7,840	15,666	50,149		50,149	2,202	52,351		6
7	Other (specify):* <u>Home Off. Ben. All.</u>							838	838		7
8	TOTAL General Services	222,030	129,000	95,004	446,034		446,034	6,452	452,486		8
	B. Health Care and Programs										
9	Medical Director			7,000	7,000		7,000		7,000		9
10	Nursing and Medical Records	714,826	66,755	6,377	787,958		787,958	5,919	793,877		10
10a	Therapy	137,280	202		137,482		137,482		137,482		10a
11	Activities	19,248	616	593	20,457		20,457	(25)	20,432		11
12	Social Services	32,114	108		32,222		32,222		32,222		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Off. Ben. All.</u>							1,033	1,033		15
16	TOTAL Health Care and Programs	903,468	67,681	13,970	985,119		985,119	6,927	992,046		16
	C. General Administration										
17	Administrative	55,160		88,000	143,160		143,160	(61,452)	81,708		17
18	Directors Fees										18
19	Professional Services			4,499	4,499		4,499	7,570	12,069		19
20	Dues, Fees, Subscriptions & Promotions			9,904	9,904		9,904	(165)	9,739		20
21	Clerical & General Office Expenses	5,720	5,926	12,245	23,891		23,891	37,407	61,298		21
22	Employee Benefits & Payroll Taxes			255,549	255,549		255,549	6,448	261,997		22
23	Inservice Training & Education			88	88		88	202	290		23
24	Travel and Seminar			12	12		12	203	215		24
25	Other Admin. Staff Transportation			5,865	5,865		5,865	2,684	8,549		25
26	Insurance-Prop.Liab.Malpractice			12,136	12,136		12,136	160	12,296		26
27	Other (specify):* <u>Home Off. Ben. All.</u>							9,485	9,485		27
28	TOTAL General Administration	60,880	5,926	388,298	455,104		455,104	2,542	457,646		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,186,378	202,607	497,272	1,886,257		1,886,257	15,921	1,902,178		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.

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			51,971	51,971		51,971	4,584	56,555			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			63,950	63,950		63,950	16,168	80,118			32
33	Real Estate Taxes			31,007	31,007		31,007	487	31,494			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			37,142	37,142		37,142	415	37,557			35
36	Other (specify):*											36
37	TOTAL Ownership			184,070	184,070		184,070	21,654	205,724			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		49,783		49,783		49,783		49,783			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			34,038	34,038		34,038		34,038			42
43	Other (specify):* Non-allowable Cost		758	94,507	95,265		95,265	(95,240)	25			43
44	TOTAL Special Cost Centers		50,541	128,545	179,086		179,086	(95,240)	83,846			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,186,378	253,148	809,887	2,249,413		2,249,413	(57,665)	2,191,748			45

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

Effingham Rehabilitation & Health Care Center

ID# 0047159

Report Period Beginning: 1/1/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (4,675)	43	1
2	X-Rays-Part A	(2,755)	43	2
3	Offset Miscellaneous Office Supplies Revenue	(161)	21	3
4	Offset Chamber of Commerce Dues	(1,175)	20	4
5	Resident Flowers	(813)	43	5
6	Disallowed Special Events	377	43	6
7	Offset Miscellaneous Activity Supplies Revenue	(25)	11	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	Total	(9,227)		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	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%	\$ 3,410	\$ 3,410	1
2	V	2 Food		Petersen Health Care, Inc.	65.00%	56	56	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	65.00%	25	25	3
4	V	4 Laundry		Petersen Health Care, Inc.	65.00%	2	2	4
5	V	5 Utilities		Petersen Health Care, Inc.	65.00%	353	353	5
6	V	6 Maintenance		Petersen Health Care, Inc.	65.00%	2,084	2,084	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	65.00%	838	838	7
8	V	10A Therapy		Petersen Health Care, Inc.	65.00%	5,919	5,919	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%	1,033	1,033	10
11	V	17 Administrative	88,000	Petersen Health Care, Inc.	65.00%	26,548	(61,452)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	65.00%	2,996	2,996	12
13	V							13
14	Total		\$ 88,000			\$ 43,264	\$ * (44,736)	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%	\$ 924	\$ 924	15	
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	65.00%	33,315	33,315	16	
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	65.00%	202	202	17	
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	65.00%	203	203	18	
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	65.00%	2,623	2,623	19	
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	65.00%	160	160	20	
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	65.00%	9,485	9,485	21	
22	V	30 Depreciation		Petersen Health Care, Inc.	65.00%	3,630	3,630	22	
23	V	32 Interest		Petersen Health Care, Inc.	65.00%	2,553	2,553	23	
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	65.00%	487	487	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%	415	415	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		\$			\$ 53,997	\$ *	53,997	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%	118	118	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%	4,574	4,574	25	
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Enterprises, LLC	100.00%	86	86	26	
27	V	21 Clerical and General Office		Petersen Health Enterprises, LLC	100.00%	4,253	4,253	27	
28	V	22 Employee Benefits & Payroll		Petersen Health Enterprises, LLC	100.00%	6,448	6,448	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%	61	61	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%	1,697	1,697	34	
35	V	32 Interest		Petersen Health Enterprises, LLC	100.00%	13,698	13,698	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	Total		\$			\$ 30,935	\$ *	30,935	39

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

Facility Name & ID Number Effingham Rehabilitation & Health Care Ce # 0047159 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	1,802,126	0.80	1.33	Salary	26,548	L17, C7	1
2	Jifi C. Jacob	Owner	Administrative	10.00						L21, C7	2
3	Cindy S. White	Owner	Administrative	10.00	105,111	0.82	1.36	Salary	1,548	L21, C7	3
4	Jacque Whitley	Owner	Administrative	10.00	94,206	0.82	1.36	Salary	1,388	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	\$ 29,484		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 Effingham Rehabilitation & Health Care Center# 0047159

Report Period Beginning:

1/1/2008Ending: 2/31/2008

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization

Petersen Health Care, Inc.

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309) 691-8113

Fax Number

(309) 691-8622

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,413,604	69	\$ 251,260	\$ 250,687	19,186	\$ 3,410	1
2	2	Food	Resident Days	1,413,604	69	4,125	0	19,186	56	2
3	3	Housekeeping	Resident Days	1,413,604	69	1,859	0	19,186	25	3
4	4	Laundry	Resident Days	1,413,604	69	110	0	19,186	2	4
5	5	Utilities	Resident Days	1,413,604	69	26,036	0	19,186	353	5
6	6	Maintenance	Resident Days	1,413,604	69	153,551	100,245	19,186	2,084	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	61,774	0	19,186	838	7
8	10	Nursing and Medical Records	Resident Days	1,413,604	69	436,084	432,530	19,186	5,919	8
9	10A	Therapy	Resident Days	1,413,604	69	0	0	19,186	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	76,136	0	19,186	1,033	10
11	17	Administrative	Resident Days	1,413,604	69	1,955,999	1,956,000	19,186	26,548	11
12	19	Professional Services	Resident Days	1,413,604	69	220,762	0	19,186	2,996	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,413,604	69	68,094	0	19,186	924	13
14	21	Clerical and General Office	Resident Days	1,413,604	69	2,454,596	2,013,896	19,186	33,315	14
15	23	Inservice Training & Education	Resident Days	1,413,604	69	14,912	0	19,186	202	15
16	24	Travel and Seminar	Resident Days	1,413,604	69	14,938	0	19,186	203	16
17	25	Other Admin. Staff Transport.	Resident Days	1,413,604	69	193,264	0	19,186	2,623	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,413,604	69	11,767	0	19,186	160	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	698,810	0	19,186	9,485	19
20	30	Depreciation	Resident Days	1,413,604	69	267,426	0	19,186	3,630	20
21	32	Interest	Resident Days	1,413,604	69	188,107	0	19,186	2,553	21
22	33	Real Estate Taxes	Resident Days	1,413,604	69	35,872	0	19,186	487	22
23	34	Rent-Facility and Grounds	Resident Days	1,413,604	69	0	0	19,186	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,413,604	69	30,580	0	19,186	415	24
25	TOTALS					\$ 7,166,062	\$ 4,753,358		\$ 97,261	25

Facility Name & ID Number Effingham Rehabilitation & Health Care Center

0047159

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	\$	19,186	\$	1
2	2	Food	Resident Days	95,327	5		19,186		2
3	3	Housekeeping	Resident Days	95,327	5		19,186		3
4	4	Laundry	Resident Days	95,327	5		19,186		4
5	5	Utilities	Resident Days	95,327	5		19,186		5
6	6	Maintenance	Resident Days	95,327	5	585	19,186	118	6
7	7	Mgmt. Allocation of Benefits	Resident Days	95,327	5		19,186		7
8	10	Nursing and Medical Records	Resident Days	95,327	5		19,186		8
9	15	Mgmt. Allocation of Benefits	Resident Days	95,327	5		19,186		9
10	17	Administrative	Resident Days	95,327	5		19,186		10
11	19	Professional Services	Resident Days	95,327	5	22,726	19,186	4,574	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	95,327	5	427	19,186	86	12
13	21	Clerical and General Office	Resident Days	95,327	5	21,132	19,186	4,253	13
14	22	Employee Benefits & Payroll	Resident Days	95,327	5	32,035	19,186	6,448	14
15	23	Inservice Training & Education	Resident Days	95,327	5		19,186		15
16	24	Travel and Seminar	Resident Days	95,327	5		19,186		16
17	25	Other Admin. Staff Transport.	Resident Days	95,327	5	301	19,186	61	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	95,327	5		19,186		18
19	27	Mgmt. Allocation of Benefits	Resident Days	95,327	5		19,186		19
20	30	Depreciation	Resident Days	95,327	5	8,430	19,186	1,697	20
21	32	Interest	Resident Days	95,327	5	68,058	19,186	13,698	21
22	33	Real Estate Taxes	Resident Days	95,327	5		19,186		22
23	34	Rent-Facility and Grounds	Resident Days	95,327	5		19,186		23
24	35	Rent-Equipment & Vehicles	Resident Days	95,327	5		19,186		24
25	TOTALS					\$ 153,694	\$	\$ 30,935	25

Facility Name & ID Number Effingham Rehabilitation & Health Care Cen # 0047159 Report Period Beginning: 1/1/2008 Ending: 12/31/2008

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10					
		Related**					Monthly Payment Required	Date of Note					Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
A. Directly Facility Related																	
Long-Term																	
1	F&M Bank of Galesburg		X	Mortgage	\$6,884.00	5/6/2008	\$ 793,243	\$ 779,396	5/6/2011	0.0695	\$ 63,603	1					
2												2					
3							Interest Income Offset				(83)	3					
4							Home Office Allocation-PHC				2,553	4					
5							Home Office Allocation-PHE				13,698	5					
Working Capital																	
6												6					
7												7					
8												8					
9	TOTAL Facility Related				\$6,884.00		\$ 793,243	\$ 779,396			\$ 79,771	9					
B. Non-Facility Related*																	
10												10					
11							Amortization of Mortgage Costs				347	11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$ 347	14					
15	TOTALS (line 9+line14)						\$ 793,243	\$ 779,396			\$ 80,118	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.		\$	29,000	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	\$	29,507	2
3. Under or (over) accrual (line 2 minus line 1).		\$	507	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	30,500	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			487	
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.		\$	31,494	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	26,514	8
	2004	28,159	9
	2005	27,375	10
	2006	27,847	11
	2007	29,507	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 Effingham Rehabilitation & Health Care Center COUNTY Effingham

FACILITY IDPH LICENSE NUMBER 0047159

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>01-14-09-200-00580</u>	<u>Long-Term Care Facility</u>	\$ <u>29,506.52</u>	\$ <u>29,506.52</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>29,506.52</u>	\$ <u>29,506.52</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: 21,644 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

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

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

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

N/A

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>176,400</u>	<u>2005</u>	<u>\$ 50,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	176,400		\$ 50,000	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	62	2005	1998	\$ 718,400	\$	30	\$ 23,947	\$ 23,947	\$ 87,805	4
5										5
6										6
7	Home Office Allocation									7
8										8
	Improvement Type**									
9	Fence		2007	19,070		15	1,271	1,271	1,907	9
10	Landscaping		2007	618		15	41	41	62	10
11	Landscaping		2007	30,800		15	2,053	2,053	3,080	11
12	Water Heater		2007	1,020		5	204	204	306	12
13	3 Awnings		2007	18,050		25	722	722	1,083	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

*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		\$	\$		\$	\$	\$
38							
39							
40							
41							
42							
43							
44							
45							
46							
47							
48	Building Booked		23,947			(23,947)	
49	Building Improvement Booked		4,291			(4,291)	
50							
51							
52	2008-Home Office Allocation-Land Improvements	667			43	43	
53	2008-Home Office Allocation-Building Improvements	9,962			239	239	
54							
55							
56							
57							
58							
59							
60							
61							
62							
63							
64							
65							
66							
67							
68							
69							
70	TOTAL (lines 4 thru 69)	\$ 798,587	\$ 28,238		\$ 28,520	\$ 282	\$ 94,243

**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	\$ 221,636	\$ 23,318	\$ 22,230	\$ (1,088)	6-10 yrs.	\$ 78,396	71
72	Current Year Purchases	9,554	415	478	63	10	478	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			5,327	5,327			74
75	TOTALS	\$ 231,190	\$ 23,733	\$ 28,035	\$ 4,302		\$ 78,874	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)	\$ 1,079,777	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 51,971	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 56,555	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 4,584	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 173,117	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	Nurses Station	\$ 19,106	92
93			93
94			94
95		\$ 19,106	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 15,587 Description: See Attached Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility		\$ 1,831	\$ 21,970	17
18					18
19					19
20					20
21	TOTAL		\$ 1,831	\$ 21,970	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. 2009 \$ _____

13. 2010 \$ _____

14. 2011 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Effingham Rehabilitation & Health Care Center

0047159

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	\$ 10,070
Dishwasher	651
Laundry Equipment	909
Maintenance Equipment	42
Copier	3,500
Home Office Allocation	415
	<u>15,587</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?</p> <p><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. CLASSROOM PORTION:</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. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
1	Licensed Occupational Therapist	10A(1)	2260	hrs	\$ 69,506				2,260	\$ 69,506	1
2	Licensed Speech and Language Development Therapist	10A(1), 10A(2)	13	hrs	412		133		13	545	2
3	Licensed Recreational Therapist		31	hrs	949				31	949	3
4	Licensed Physical Therapist	10A(1),10A(2)	2160	hrs	66,413		69		2,160	66,482	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			49,783			49,783	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				\$ 137,280		\$ 49,985		4,464	\$ 187,265	14

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

Facility Name & ID Number Effingham Rehabilitation & Health Care Center

0047159

Report Period Beginning: 1/1/2008

Ending: 12/31/2008

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2008

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 162,970	\$ 162,970	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>N/A</u>)	657,568	657,568	3
4	Supply Inventory (priced at <u> </u>)			4
5	Short-Term Investments			5
6	Prepaid Insurance	15,335	15,335	6
7	Other Prepaid Expenses	9,338	9,338	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u> </u>			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 845,211	\$ 845,211	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	100,488	50,000	13
14	Buildings, at Historical Cost	718,400	728,362	14
15	Leasehold Improvements, at Historical Cost	19,070	70,225	15
16	Equipment, at Historical Cost	231,190	231,190	16
17	Accumulated Depreciation (book methods)	(169,865)	(173,117)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify): <u> </u>			22
23	Other(specify): <u>Construction in Progress</u>	19,106	19,106	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 918,389	\$ 925,766	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,763,600	\$ 1,770,977	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 311,903	\$ 311,903	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	75,988	75,988	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,649	2,649	31
32	Accrued Real Estate Taxes(Sch.IX-B)	30,500	30,500	32
33	Accrued Interest Payable	4,974	4,974	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	63,484	63,484	36
37	<u> </u>			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 489,498	\$ 489,498	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	779,396	779,396	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u> </u>			43
44	<u> </u>			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 779,396	\$ 779,396	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,268,894	\$ 1,268,894	46
47	TOTAL EQUITY(page 18, line 24)	\$ 494,706	\$ 502,083	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,763,600	\$ 1,770,977	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 260,725	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 260,725	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	233,981	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)	\$ 233,981	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)	\$ 494,706	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	\$ 1,956,177	1
2	Discounts and Allowances for all Levels	184,181	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,140,358	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	251,882	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 251,882	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	434	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	82,132	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	5,948	20
21	Other Medical Services	2,371	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 90,885	23
	D. Non-Operating Revenue		
24	Contributions	25	24
25	Interest and Other Investment Income***	83	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 108	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Revenue</u>	161	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 161	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,483,394	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	446,034	31
32	Health Care	985,119	32
33	General Administration	455,104	33
	B. Capital Expense		
34	Ownership	184,070	34
	C. Ancillary Expense		
35	Special Cost Centers	145,048	35
36	Provider Participation Fee	34,038	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,249,413	40
41	Income before Income Taxes (line 30 minus line 40)**	233,981	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 233,981	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 Effingham Rehabilitation & Health Care Center

0047159

Report Period Beginning: 1/1/2008

Ending: 12/31/2008

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,124	2,124	\$ 56,897	\$ 26.79	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,187	4,311	91,554	21.24	3
4	Licensed Practical Nurses	10,285	10,500	187,333	17.84	4
5	CNAs & Orderlies	35,188	36,219	358,179	9.89	5
6	CNA Trainees					6
7	Licensed Therapist	4,365	4,464	137,280	30.75	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,776	1,832	18,602	10.15	9
10	Activity Assistants	72	72	646	8.97	10
11	Social Service Workers	2,593	2,673	32,114	12.01	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	27,485	13.21	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,388	10,658	83,128	7.80	15
16	Dishwashers					16
17	Maintenance Workers	2,080	2,080	26,643	12.81	17
18	Housekeepers	4,268	4,561	33,585	7.36	18
19	Laundry	5,634	5,845	51,189	8.76	19
20	Administrator	1,892	1,972	55,160	27.97	20
21	Assistant Administrator					21
22	Other Administrative	520	520	5,720	11.00	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	575	575	4,620	8.03	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Care Plan Coord.</u>	1,077	1,077	16,243	15.08	33
34	TOTAL (lines 1 - 33)	89,104	91,563	\$ 1,186,378 *	\$ 12.96	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 7,000	9(3)	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 550	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)	\$ 7,550		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Nathan Scholes	Administrator	0	\$ 8,667	Workers' Compensation Insurance	\$ 127,489	IDPH License Fee	\$		
Lola White	Administrator	0	46,493	Unemployment Compensation Insurance	20,954	Advertising: Employee Recruitment	2,246		
				FICA Taxes	88,383	Health Care Worker Background Check (Indicate # of checks performed)			
				Employee Health Insurance	13,052	Patient Background Checks	93		
				Employee Meals		Miscellaneous Licenses & Permits	88		
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Dues & Subscriptions	1,175		
				Employee Relations	12,119	IHCA Dues	5,465		
						Home Office Allocation	1,010		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 55,160			Less: Public Relations Expense	(1,175)		
						Non-allowable advertising	()		
						Yellow page advertising	()		
						TOTAL (agree to Sch. V, line 20, col. 8)	\$ 9,739		
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)					
Description			Amount						
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 88,000						
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 88,000	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	
E-Health Data Solutions	Computer Services		\$ 2,700				Out-of-State Travel	\$	
Consolidated Communications	Computer Services		50						
LTC Solutions	Computer Services		1,600				In-State Travel		
U.S. Laser	Computer Services		149						
							Seminar Expense	12	
							Home Office Allocation	203	
							Entertainment Expense	()	
							(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 4,499	TOTAL			\$	TOTAL	\$ 215

* Attach copy of IMRF notifications

**See instructions.

Effingham Rehabilitation & Health Care Center

0047159

Period Beginning 1/1/2008

Period End 12/31/2008

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		4,499

Home Office Allocation

Heyl, Royster, Voelker & Allen	Legal	109
GoffWilson, P.A.	Legal	364
Ginoli & Company	Accountants	5,458
RSM McGladrey	Accountants	8
Miscellaneous Vendors	Computer Services	42
Emdeon Business Services	Computer Services	59
Advanced Answers on Demand	Computer Services	688
Access 2 Go	Computer Services	203
Ivans	Computer Services	105
Kemper Technology	Computer Services	373
VisionShare	Computer Services	40
Logmein	Computer Services	29
Comm Net Communiations	Computer Services	10
Charter Communications	Computer Services	9
Advanced System Designs	Computer Services	13
Consolidated Communications	Computer Services	8
Miscellaneous Vendors	Miscellaneous	52

Total (agree to Schedule V, line 19, column 8)		<u>12,069</u>
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Effingham Rehabilitation & Health Care Center

0047159

Period Beginning 1/1/2008

Period End 12/31/2008

XIX. SUPPORT SCHEDULES

Schedule 21B

A. Administrative Salaries

Name	Function	Ownership %	Amount
Nathan Scholes	Adminstrator	0	8,667
Lola White	Adminstrator	0	46,493
	Total		<u>55,160</u>

Facility Name & ID Number Effingham Rehabilitation & Health Care Center

0047159

Report Period Beginning:

1/1/2008

Ending:

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. 5,465 -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. \$ 10,342 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. \$ 34,038
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. \$ 434
- (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