



Facility Name & ID Number Orchard View Rehab & Health Care

# 0049007 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	75	Skilled (SNF)	75	27,450	1
2		Skilled Pediatric (SNF/PED)			2
3	48	Intermediate (ICF)	48	17,568	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	123	TOTALS	123	45,018	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			817	817	8
9	SNF/PED					9
10	ICF	14,609	2,951		17,560	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,609	2,951	817	18,377	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 40.82%

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)

Jail Meals

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 7/1/2007

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

YES

Date 7/1/2007

NO

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

YES

NO

If YES, enter number of beds certified 48 and days of care provided 817

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 Orchard View Rehab & Health Care # 0049007 Report Period Beginning: 1/1/2008 Ending: 12/31/2008

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	196,870	22,572	2,685	222,127		222,127	3,266	225,393		1
2	Food Purchase		148,971		148,971		148,971	(98,471)	50,500		2
3	Housekeeping	98,703	16,879		115,582		115,582	24	115,606		3
4	Laundry	62,473	12,274		74,747		74,747	1	74,748		4
5	Heat and Other Utilities			114,340	114,340		114,340	338	114,678		5
6	Maintenance	56,548	19,801	48,498	124,847		124,847	1,996	126,843		6
7	Other (specify):* <u>Home Off. Ben. All.</u>							803	803		7
8	<b>TOTAL General Services</b>	414,594	220,497	165,523	800,614		800,614	(92,043)	708,571		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			14,400	14,400		14,400		14,400		9
10	Nursing and Medical Records	1,153,046	45,789	42,083	1,240,918		1,240,918	1,298	1,242,216		10
10a	Therapy			50,268	50,268		50,268		50,268		10a
11	Activities	31,436	2,898	1,586	35,920		35,920	(50)	35,870		11
12	Social Services	27,169			27,169		27,169		27,169		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Off. Ben. All.</u>							990	990		15
16	<b>TOTAL Health Care and Programs</b>	1,211,651	48,687	108,337	1,368,675		1,368,675	2,238	1,370,913		16
	<b>C. General Administration</b>										
17	Administrative	76,215			76,215		76,215	25,428	101,643		17
18	Directors Fees										18
19	Professional Services			10,302	10,302		10,302	4,732	15,034		19
20	Dues, Fees, Subscriptions & Promotions			9,105	9,105		9,105	444	9,549		20
21	Clerical & General Office Expenses	34,181	4,870	7,617	46,668		46,668	34,375	81,043		21
22	Employee Benefits & Payroll Taxes			195,694	195,694		195,694		195,694		22
23	Inservice Training & Education			228	228		228	251	479		23
24	Travel and Seminar							194	194		24
25	Other Admin. Staff Transportation			8,701	8,701		8,701	3,145	11,846		25
26	Insurance-Prop.Liab.Malpractice			24,962	24,962		24,962	238	25,200		26
27	Other (specify):* <u>Home Off. Ben. All.</u>							9,085	9,085		27
28	<b>TOTAL General Administration</b>	110,396	4,870	256,609	371,875		371,875	77,892	449,767		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,736,641	274,054	530,469	2,541,164		2,541,164	(11,913)	2,529,251		29

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

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

Facility Name &amp; ID Number

Orchard View Rehab &amp; Health Care

#0049007

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			83,121	83,121		83,121	(13,390)	69,731			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			116,507	116,507		116,507	9,594	126,101			32
33	Real Estate Taxes			7,499	7,499		7,499	466	7,965			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			4,523	4,523		4,523	445	4,968			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			211,650	211,650		211,650	(2,885)	208,765			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		24,335		24,335		24,335		24,335			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			67,528	67,528		67,528		67,528			42
43	Other (specify):* Non-allowable Cost	33,653	1,248	44,397	79,298		79,298	(79,298)				43
44	<b>TOTAL Special Cost Centers</b>	33,653	25,583	111,925	171,161		171,161	(79,298)	91,863			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,770,294	299,637	854,044	2,923,975		2,923,975	(94,096)	2,829,879			45

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



## Orchard View Rehab &amp; Health Care

ID# 0049007

Report Period Beginning: 1/1/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (1,728)	43	1
2	X-Rays-Part A	(597)	43	2
3	Offset Miscellaneous Nursing Supplies Revenue	(4,371)	10	3
4	Offset Jail Meals income	(93,406)	2	4
5	Offset Miscellaneous Office Supplies Revenue	(376)	21	5
6	Offset Chamber of Commerce Dues	(748)	20	6
7	Resident Flowers	(434)	43	7
8	Pet Expense	(286)	43	8
9	Offset activity revenue	(50)	11	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(101,996)		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%	\$ 3,266	\$ 3,266	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	54	54	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	24	24	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	1	1	4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	338	338	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	1,996	1,996	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	803	803	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	5,669	5,669	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%	990	990	10
11	V	17 Administrative		Petersen Health Care, Inc.	100.00%	25,428	25,428	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	2,870	2,870	12
13	V							13
14	Total		\$			\$ 41,439	\$ * 41,439	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%	\$ 885	\$	885	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	31,910		31,910	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	194		194	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	194		194	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	2,512		2,512	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	153		153	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	9,085		9,085	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	3,477		3,477	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	2,445		2,445	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	466		466	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%	398		398	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	<b>Total</b>		\$			\$ 51,719	\$ *	51,719	39

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

Facility Name & ID Number Orchard View Rehab & Health Care# 0049007Report Period Beginning: 1/1/2008Ending: 12/31/2008

## VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1 Dietary	\$	Petersen Companies, LLC	100.00%	\$ 0	\$	15	
16	V	2 Food		Petersen Companies, LLC	100.00%	0		16	
17	V	3 Housekeeping		Petersen Companies, LLC	100.00%	0		17	
18	V	4 Laundry		Petersen Companies, LLC	100.00%	0		18	
19	V	5 Utilities		Petersen Companies, LLC	100.00%	0		19	
20	V	6 Maintenance		Petersen Companies, LLC	100.00%	0		20	
21	V	7 Mgmt. Allocation of Benefits		Petersen Companies, LLC	100.00%	0		21	
22	V	10 Nursing and Medical Records		Petersen Companies, LLC	100.00%	0		22	
23	V	10A Therapy		Petersen Companies, LLC	100.00%	0		23	
24	V	15 Mgmt. Allocation of Benefits		Petersen Companies, LLC	100.00%	0		24	
25	V	17 Administrative		Petersen Companies, LLC	100.00%	0		25	
26	V	19 Professional Services		Petersen Companies, LLC	100.00%	1,862	1,862	26	
27	V	20 Dues, Fees, Subs & Promotions		Petersen Companies, LLC	100.00%	307	307	27	
28	V	21 Clerical and General Office		Petersen Companies, LLC	100.00%	2,841	2,841	28	
29	V	23 Inservice Training & Education		Petersen Companies, LLC	100.00%	57	57	29	
30	V	24 Travel and Seminar		Petersen Companies, LLC	100.00%	0		30	
31	V	25 Other Admin. Staff Transport.		Petersen Companies, LLC	100.00%	633	633	31	
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Companies, LLC	100.00%	85	85	32	
33	V	27 Mgmt. Allocation of Benefits		Petersen Companies, LLC	100.00%	0		33	
34	V	30 Depreciation		Petersen Companies, LLC	100.00%	924	924	34	
35	V	32 Interest		Petersen Companies, LLC	100.00%	8,294	8,294	35	
36	V	33 Real Estate Taxes		Petersen Companies, LLC	100.00%	0		36	
37	V	34 Rent-Facility and Grounds		Petersen Companies, LLC	100.00%	0		37	
38	V	35 Rent-Equipment & Vehicles		Petersen Companies, LLC	100.00%	47	47	38	
39	Total		\$			\$ 15,050	\$ *	15,050	39

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

Facility Name & ID Number Orchard View Rehab & Health Care # 0049007 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	1,803,246	0.76	1.27	Salary	25,428	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	\$ 25,428		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 Orchard View Rehab & Health Care

# 0049007

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	18,377	\$ 3,266	1
2	2	Food	Resident Days	1,413,604	69	4,125	0	18,377	54	2
3	3	Housekeeping	Resident Days	1,413,604	69	1,859	0	18,377	24	3
4	4	Laundry	Resident Days	1,413,604	69	110	0	18,377	1	4
5	5	Utilities	Resident Days	1,413,604	69	26,036	0	18,377	338	5
6	6	Maintenance	Resident Days	1,413,604	69	153,551	100,245	18,377	1,996	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	61,774	0	18,377	803	7
8	10	Nursing and Medical Records	Resident Days	1,413,604	69	436,084	432,530	18,377	5,669	8
9	10A	Therapy	Resident Days	1,413,604	69	0	0	18,377	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	76,136	0	18,377	990	10
11	17	Administrative	Resident Days	1,413,604	69	1,955,999	1,956,000	18,377	25,428	11
12	19	Professional Services	Resident Days	1,413,604	69	220,762	0	18,377	2,870	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,413,604	69	68,094	0	18,377	885	13
14	21	Clerical and General Office	Resident Days	1,413,604	69	2,454,596	2,013,896	18,377	31,910	14
15	23	Inservice Training & Education	Resident Days	1,413,604	69	14,912	0	18,377	194	15
16	24	Travel and Seminar	Resident Days	1,413,604	69	14,938	0	18,377	194	16
17	25	Other Admin. Staff Transport.	Resident Days	1,413,604	69	193,264	0	18,377	2,512	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,413,604	69	11,767	0	18,377	153	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	698,810	0	18,377	9,085	19
20	30	Depreciation	Resident Days	1,413,604	69	267,426	0	18,377	3,477	20
21	32	Interest	Resident Days	1,413,604	69	188,107	0	18,377	2,445	21
22	33	Real Estate Taxes	Resident Days	1,413,604	69	35,872	0	18,377	466	22
23	34	Rent-Facility and Grounds	Resident Days	1,413,604	69	0	0	18,377	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,413,604	69	30,580	0	18,377	398	24
25	TOTALS					\$ 7,166,062	\$ 4,753,358		\$ 93,158	25

Facility Name & ID Number Orchard View Rehab & Health Care

# 0049007

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	227,342	13	\$	18,377	\$	1
2	2	Food	Resident Days	227,342	13		18,377		2
3	3	Housekeeping	Resident Days	227,342	13		18,377		3
4	4	Laundry	Resident Days	227,342	13		18,377		4
5	5	Utilities	Resident Days	227,342	13		18,377		5
6	6	Maintenance	Resident Days	227,342	13		18,377		6
7	7	Mgmt. Allocation of Benefits	Resident Days	227,342	13		18,377		7
8	10	Nursing and Medical Records	Resident Days	227,342	13		18,377		8
9	10A	Therapy	Resident Days	227,342	13		18,377		9
10	15	Mgmt. Allocation of Benefits	Resident Days	227,342	13		18,377		10
11	17	Administrative	Resident Days	227,342	13		18,377		11
12	19	Professional Services	Resident Days	227,342	13	23,031	18,377	1,862	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	227,342	13	3,794	18,377	307	13
14	21	Clerical and General Office	Resident Days	227,342	13	35,146	18,377	2,841	14
15	23	Inservice Training & Education	Resident Days	227,342	13	706	18,377	57	15
16	24	Travel and Seminar	Resident Days	227,342	13		18,377		16
17	25	Other Admin. Staff Transport.	Resident Days	227,342	13	7,835	18,377	633	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	227,342	13	1,053	18,377	85	18
19	27	Mgmt. Allocation of Benefits	Resident Days	227,342	13		18,377		19
20	30	Depreciation	Resident Days	227,342	13	11,428	18,377	924	20
21	32	Interest	Resident Days	227,342	13	102,603	18,377	8,294	21
22	33	Real Estate Taxes	Resident Days	227,342	13		18,377		22
23	34	Rent-Facility and Grounds	Resident Days	227,342	13		18,377		23
24	35	Rent-Equipment & Vehicles	Resident Days	227,342	13	585	18,377	47	24
25	TOTALS					\$ 186,181	\$	\$ 15,050	25

Facility Name &amp; ID Number

Orchard View Rehab &amp; Health Care

# 0049007

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 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
<b>A. Directly Facility Related</b>												
<b>Long-Term</b>												
1	Citizens First National Bank		X	Mortgage	\$13,346.04	06/29/07	\$ 1,400,000	\$ 1,327,184	07/05/12	Varies	\$ 108,111	1
2												2
3							Interest Income Offset				(1,145)	3
4							Home Office Allocation-PHC				2,445	4
5							Home Office Allocation-PC				8,294	5
<b>Working Capital</b>												
6	Citizens First National Bank		X	Line of Credit	Interest only	5/29/08	500,000	1,552	5/29/09	Varies	45	6
7												7
8												8
9	<b>TOTAL Facility Related</b>				\$13,346.04		\$ 1,900,000	\$ 1,328,736			\$ 117,750	9
<b>B. Non-Facility Related*</b>												
10							Amortization Expense				8,351	10
11												11
12												12
13												13
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ 8,351	14
15	<b>TOTALS (line 9+line14)</b>						\$ 1,900,000	\$ 1,328,736			\$ 126,101	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)**

**B. Real Estate Taxes**

**Important**, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2007 report.		\$	<b>40,000</b>	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2007	\$	<b>15,499</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(24,501)</b>	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>32,000</b>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.				
			<b>Home Office Allocation</b>	
<b>TOTAL REFUND</b>	<b>\$</b>	<b>For</b>	<b>Tax Year.</b>	<b>(Attach a copy of the real estate tax appeal board's decision.)</b>
				\$
			<b>466</b>	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>7,965</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003		8
	2004		9
	2005		10
	2006		11
	2007	<b>15,499</b>	12

Accrual based on prior year tax bill.

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

**NOTES:**

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

**IMPORTANT NOTICE**

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

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

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

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

**2007 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Orchard View Rehab & Health Care COUNTY Bureau

FACILITY IDPH LICENSE NUMBER 0049007

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>15-23-400-003</u>	<u>Long-Term Care Facility</u>	\$ <u>15,016.04</u>	\$ <u>15,016.04</u>
2. <u>15-24-300-006</u>	<u>Long-Term Care Facility</u>	\$ <u>279.10</u>	\$ <u>279.10</u>
3. <u>15-24-400-011</u>	<u>Long-Term Care Facility</u>	\$ <u>203.36</u>	\$ <u>203.36</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>15,498.50</u>	\$ <u>15,498.50</u>

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

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

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

Facility Name & ID Number Orchard View Rehab & Health Care

# 0049007

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 51,745 B. General Construction Type: Exterior Concrete Brick Frame Block Number of Stories 1

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

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

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

N/A

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

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

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

**XI. OWNERSHIP COSTS:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>51,745</u>	<u>2007</u>	<u>\$ 55,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>51,745</b>		<b>\$ 55,000</b>	<b>3</b>

Facility Name & ID Number Orchard View Rehab & Health Care

# 0049007

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	123	2007	1961	\$ 1,120,000	\$	30	\$ 37,333	\$ 37,333	\$ 56,000	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Original Land Improvements		2007	15,000		15	1,000	1,000	1,500	9
10	Fire Alarm		2007	2,148		15	143	143	215	10
11	Exterior Sign		2007	1,749		15	117	117	175	11
12	Plumbing-Kitchen		2007	4,300		15	287	287	430	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	Building Booked				44,800			(44,800)		28
29	Building Improvement Booked				2,872			(2,872)		29
30										30
31										31
32	2008-Home Office Allocation-Land Improvements			638			41	41		32
33	2008-Home Office Allocation-Building Improvements			9,542			229	229		33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	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	\$ 210,000	\$ 30,000	\$ 21,000	\$ (9,000)	10	\$ 31,500	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Home Office Allocation			4,131	4,131			74
75	TOTALS	\$ 210,000	\$ 30,000	\$ 25,131	\$ (4,869)		\$ 31,500	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	Facility	2007 Ford E-150	2007	\$ 27,248	\$ 5,450	\$ 5,450	\$	5	\$ 8,175	76
77										77
78										78
79										79
80	TOTALS			\$ 27,248	\$ 5,450	\$ 5,450	\$		\$ 8,175	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)	\$ 1,445,625	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 83,122	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 69,731	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (13,391)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 97,995	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88	N/A				88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		93
94			94
95		\$	95

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.  YES  NO

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

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

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

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental? \_\_\_\_\_

YES  NO

16. Rental Amount for movable equipment: \$ 4,968 Description: See Attached Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18			<u>N/A</u>		18
19					19
20					20
21	TOTAL		\$ _____	\$ _____	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_ /2009 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2010 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2011 \$ \_\_\_\_\_

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

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

**Orchard View Rehab & Health Care**

**0049007**

**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	\$	227
Dishwasher		295
Laundry Equipment		95
Copier		3,906
Home Office Allocation		445
		<u>4,968</u>

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	1,350	\$ 20,245	\$	1,350	\$ 20,245	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		8	127		8	127	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		1,993	29,896		1,993	29,896	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescripts				24,335		24,335	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____									13
14	<b>TOTAL</b>			\$	3,351	\$ 50,268	\$ 24,335	3,351	\$ 74,603	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 &amp; ID Number Orchard View Rehab &amp; Health Care

# 0049007

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 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ (801,073)	\$ (801,073)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>N/A</u> )	210,733	210,733	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	30,484	30,484	6
7	Other Prepaid Expenses	12,208	12,208	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Employee loans</u>	364	364	9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ (547,284)	\$ (547,284)	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		55,000	13
14	Buildings, at Historical Cost	1,190,000	1,129,542	14
15	Leasehold Improvements, at Historical Cost	8,197	23,835	15
16	Equipment, at Historical Cost	237,248	237,248	16
17	Accumulated Depreciation (book methods)	(125,462)	(97,995)	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>Loan costs</u>	2,651	2,651	22
23	Other(specify): _____			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 1,312,634	\$ 1,350,281	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 765,350	\$ 802,997	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 282,789	\$ 282,789	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,552	1,552	29
30	Accrued Salaries Payable	58,386	58,386	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,897	3,897	31
32	Accrued Real Estate Taxes(Sch.IX-B)	32,000	32,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Payroll Withholdings</u>	32,161	32,161	36
37	_____			37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 410,785	\$ 410,785	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,327,184	1,327,184	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>Due to Prior Owner</u>	9,406	9,406	43
44	_____			44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 1,336,590	\$ 1,336,590	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 1,747,375	\$ 1,747,375	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ (982,025)	\$ (944,378)	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 765,350	\$ 802,997	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(272,390)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(272,390)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(709,635)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(709,635)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(982,025)</b>	<b>24</b> *

\* This must agree with page 17, line 47.

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

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

1

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 1,943,746	1
2	Discounts and Allowances for all Levels	37,347	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 1,981,093	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	76,641	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 76,641	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	5,119	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	6,300	16
17	Sale of Drugs	40,665	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	4,199	20
21	Other Medical Services	975	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 57,258	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions	50	24
25	Interest and Other Investment Income***	1,145	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 1,195	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Miscellaneous Revenue</u>	4,747	28
28a	<u>Jail Meals Revenue</u>	93,406	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 98,153	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,214,340	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	800,614	31
32	Health Care	1,368,675	32
33	General Administration	371,875	33
	<b>B. Capital Expense</b>		
34	Ownership	211,650	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	103,633	35
36	Provider Participation Fee	67,528	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,923,975	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(709,635)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (709,635)	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 Orchard View Rehab & Health Care

# 0049007

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	1,781	1,781	\$ 47,636	\$ 26.75	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,740	3,740	81,066	21.68	3
4	Licensed Practical Nurses	17,811	17,952	355,041	19.78	4
5	CNAs & Orderlies	49,658	49,883	581,033	11.65	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,443	1,443	15,229	10.55	9
10	Activity Assistants	1,846	1,944	16,207	8.34	10
11	Social Service Workers	2,212	2,212	27,169	12.28	11
12	Dietician					12
13	Food Service Supervisor	3,569	3,569	47,359	13.27	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,420	17,610	149,511	8.49	15
16	Dishwashers					16
17	Maintenance Workers	3,978	4,058	56,548	13.93	17
18	Housekeepers	11,022	11,134	98,703	8.87	18
19	Laundry	6,822	6,908	62,473	9.04	19
20	Administrator	2,057	2,057	76,215	37.05	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,819	2,819	34,181	12.13	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	2,051	2,051	22,181	10.81	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Sch. 20A</u>	5,427	5,489	99,742	18.17	33
34	TOTAL (lines 1 - 33)	133,656	134,650	\$ 1,770,294 *	\$ 13.15	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	47	\$ 2,685	1(3)	35
36	Medical Director	Monthly	14,400	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,200	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	47	\$ 18,285		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	659	\$ 32,763	10(3)	50
51	Licensed Practical Nurses	210	7,954	10(3)	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	869	\$ 40,717		53

**Orchard View Rehab & Health Care**

**0049007**

**Period Beginning 1/1/2008**

**Period End 12/31/2008**

**Schedule 20A**

**XVIII. Staffing and Salary Costs**

	<b># of Hrs. Actually Worked</b>	<b># of Hrs. Paid and Accrued</b>	<b>Reporting Period Total Salaries, Wages</b>	<b>Average Hourly Wage</b>
<b>Care Plan Coordinator</b>	<b>2,080</b>	<b>2,080</b>	<b>50,962</b>	<b>24.50</b>
<b>Marketing</b>	<b>2,072</b>	<b>2,072</b>	<b>33,653</b>	<b>16.24</b>
<b>Alzheimer's Coordinator</b>	<b>1,275</b>	<b>1,337</b>	<b>15,127</b>	<b>11.31</b>
<b>TOTAL (lines 1 - 35)</b>	<b>5,427</b>	<b>5,489</b>	<b>99,742</b>	

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
<u>Kathryn Langan</u>	<u>Administrator</u>	<u>0</u>	\$ <u>72,376</u>	<u>Workers' Compensation Insurance</u>	\$ <u>64,798</u>	<u>IDPH License Fee</u>	\$ <u>899</u>		
<u>Lori Walsh</u>	<u>Administrator</u>	<u>0</u>	<u>3,839</u>	<u>Unemployment Compensation Insurance</u>	<u>37,200</u>	<u>Advertising: Employee Recruitment</u>	<u>3,532</u>		
				<u>FICA Taxes</u>	<u>130,027</u>	<u>Health Care Worker Background Check</u>			
				<u>Employee Health Insurance</u>	<u>(38,956)</u>	(Indicate # of checks performed )			
				<u>Employee Meals</u>		<u>Patient Background Checks</u>	<u>125</u>		
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Miscellaneous Licenses &amp; Permits</u>	<u>1,416</u>		
				<u>Employee Relations</u>	<u>1,331</u>	<u>Miscellaneous Dues &amp; Subscriptions</u>	<u>838</u>		
				<u>Employee Retirement</u>	<u>1,294</u>	<u>IHCA Dues</u>	<u>1,170</u>		
<b>TOTAL (agree to Schedule V, line 17, col. 1)</b>			<b>\$ <u>76,215</u></b>			<u>Home Office Allocation</u>	<u>1,192</u>		
<b>(List each licensed administrator separately.)</b>									
<b>B. Administrative - Other</b>									
Description			Amount						
<u>N/A</u>			\$						
<b>TOTAL (agree to Schedule V, line 17, col. 3)</b>			<b>\$</b>	<b>TOTAL (agree to Schedule V, line 22, col.8)</b>			<b>\$ <u>195,694</u></b>	<b>TOTAL (agree to Sch. V, line 20, col. 8)</b>	
<b>(Attach a copy of any management service agreement)</b>									
<b>C. Professional Services</b>				<b>E. Schedule of Non-Cash Compensation Paid to Owners or Employees</b>			<b>G. Schedule of Travel and Seminar**</b>		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
<u>Network Business Systems</u>	<u>Computer Services</u>		\$ <u>700</u>				<u>Out-of-State Travel</u>	\$	
<u>LTC Solutions</u>	<u>Computer Services</u>		<u>1,600</u>						
<u>E-Health Data Solutions</u>	<u>Computer Services</u>		<u>2,700</u>				<u>In-State Travel</u>		
<u>Brown &amp; James</u>	<u>Legal Services</u>		<u>1,256</u>						
<u>Lindon Engineering</u>	<u>Accounting Services</u>		<u>4,046</u>	<u>N/A</u>					
							<u>Seminar Expense</u>		
							<u>Home Office Allocation</u>	<u>194</u>	
							<u>Entertainment Expense</u>	( )	
<b>TOTAL (agree to Schedule V, line 19, column 3)</b>			<b>\$ <u>10,302</u></b>	<b>TOTAL</b>			<b>\$</b>	<b>TOTAL (agree to Sch. V, line 24, col. 8)</b>	
<b>(If total legal fees exceed \$5,000, attach copy of invoices.)</b>									

\* Attach copy of IMRF notifications

\*\*See instructions.

**Orchard View Rehab & Health Care**

**0049007**

**Period Beginning 1/1/2008**

**Period End 12/31/2008**

**Schedule 21A**

**XIX. SUPPORT SCHEDULE**

**C. Professional Services**

<b>Vendor/Payee</b>	<b>Type</b>	<b>Amount</b>
Total (agree to Schedule V, line 19, column 3)		10,302

**Home Office Allocation**

Heyl, Royster, Voelker & Allen	Legal	104
GoffWilson, P.A.	Legal	348
Ginoli & Company	Accountants	2,708
RSM McGladrey	Accountants	8
Miscellaneous Vendors	Computer Services	41
Emdeon Business Services	Computer Services	56
Advanced Answers on Demand	Computer Services	659
Access 2 Go	Computer Services	195
Ivans	Computer Services	101
Kemper Technology	Computer Services	357
VisionShare	Computer Services	38
Logmein	Computer Services	27
Comm Net Communiations	Computer Services	10
Charter Communications	Computer Services	8
Advanced System Designs	Computer Services	13
Consolidated Communications	Computer Services	8
Miscellaneous Vendors	Miscellaneous	51

Total (agree to Schedule V, line 19, column 8)		<u>15,034</u>
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**Orchard View Rehab & Health Care  
0049007**

**Period Beginning 1/1/2008**

**Period End 12/31/2008**

**XIX. SUPPORT SCHEDULES**

**Schedule 21B**

**A. Administrative Salaries**

<b>Name</b>	<b>Function</b>	<b>Ownership %</b>	<b>Amount</b>
<b>Kathryn Langan</b>	Administrator	0	72,376
<b>Lori Walsh</b>	Administrator	0	3,839
	<b>Total</b>		<u>76,215</u>



Facility Name &amp; ID Number Orchard View Rehab &amp; Health Care

# 0049007

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. 1,170 -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? N/A
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line N/A
- (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. \$ 67,528  
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. \$ 98,525
- (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