

Facility Name & ID Number South Elgin Rehabilitation & Health Care Center

0047621 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	14	Skilled (SNF)	14	5,124	1
2		Skilled Pediatric (SNF/PED)			2
3	76	Intermediate (ICF)	76	27,816	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	90	TOTALS	90	32,940	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			2,257	2,257	8
9	SNF/PED					9
10	ICF	16,340	2,013		18,353	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,340	2,013	2,257	20,610	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.57%

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

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

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

None

F. Does the facility maintain a daily midnight census?

Yes

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

YES

NO

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

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

YES

NO

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

Date started 10/1/2005

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

YES

Date 10/1/2005

NO

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

YES

NO

If YES, enter number of beds certified 14 and days of care provided 2,257

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 South Elgin Rehabilitation & Health Care Ce # 0047621 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	112,402	11,193	5,368	128,963		128,963	3,663	132,626		1
2	Food Purchase		118,993		118,993		118,993	(510)	118,483		2
3	Housekeeping	142,427	17,341		159,768		159,768	27	159,795		3
4	Laundry	11,165	6,566		17,731		17,731	2	17,733		4
5	Heat and Other Utilities			71,490	71,490		71,490	380	71,870		5
6	Maintenance	26,931	10,846	50,776	88,553		88,553	3,364	91,917		6
7	Other (specify):* <u>Home Off. Ben. All.</u>							1,248	1,248		7
8	TOTAL General Services	292,925	164,939	127,634	585,498		585,498	8,174	593,672		8
	B. Health Care and Programs										
9	Medical Director			16,800	16,800		16,800		16,800		9
10	Nursing and Medical Records	1,116,336	116,980	6,171	1,239,487		1,239,487	1,738	1,241,225		10
10a	Therapy			454,326	454,326		454,326		454,326		10a
11	Activities	31,189	815	201	32,205		32,205		32,205		11
12	Social Services	79,730			79,730		79,730	9	79,739		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Off. Ben. All.</u>							1,110	1,110		15
16	TOTAL Health Care and Programs	1,227,255	117,795	477,498	1,822,548		1,822,548	2,857	1,825,405		16
	C. General Administration										
17	Administrative	80,422		126,000	206,422		206,422	(95,245)	111,177		17
18	Directors Fees										18
19	Professional Services			4,580	4,580		4,580	6,105	10,685		19
20	Dues, Fees, Subscriptions & Promotions			21,526	21,526		21,526	667	22,193		20
21	Clerical & General Office Expenses	31,696	5,645	13,831	51,172		51,172	41,132	92,304		21
22	Employee Benefits & Payroll Taxes			201,992	201,992		201,992		201,992		22
23	Inservice Training & Education			268	268		268	232	500		23
24	Travel and Seminar							233	233		24
25	Other Admin. Staff Transportation			9,437	9,437		9,437	8,025	17,462		25
26	Insurance-Prop.Liab.Malpractice			67,948	67,948		67,948	172	68,120		26
27	Other (specify):* <u>Home Off. Ben. All.</u>							11,769	11,769		27
28	TOTAL General Administration	112,118	5,645	445,582	563,345		563,345	(26,910)	536,435		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,632,298	288,379	1,050,714	2,971,391		2,971,391	(15,879)	2,955,512		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			28,740	28,740		28,740	576	29,316			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			48,670	48,670		48,670	13,167	61,837			32
33	Real Estate Taxes			55,174	55,174		55,174	523	55,697			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			43,385	43,385		43,385	446	43,831			35
36	Other (specify):*											36
37	TOTAL Ownership			175,969	175,969		175,969	14,712	190,681			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		85,305		85,305		85,305		85,305			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			49,410	49,410		49,410		49,410			42
43	Other (specify):* Non-allowable Cost	15,402	1,360	125,641	142,403		142,403	(142,403)				43
44	TOTAL Special Cost Centers	15,402	86,665	175,051	277,118		277,118	(142,403)	134,715			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,647,700	375,044	1,401,734	3,424,478		3,424,478	(143,570)	3,280,908			45

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

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(3,594)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(4,602)	30		9
10	Interest and Other Investment Income	(18)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(36)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(4,098)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(98,592)	43		24
25	Fund Raising, Advertising and Promotional	(19,639)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg. 5A	(22,204)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (152,783)		\$	30

BHF USE ONLY							
48		49		50		51	

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	9,213	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 9,213		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (143,570)		37

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

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

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

South Elgin Rehabilitation & Health Care Center

ID# 0047621

Report Period Beginning: 1/1/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (13,022)	43	1
2	X-Rays-Part A	(2,588)	43	2
3	Offset Miscellaneous Nursing Supplies Revenue	(4,621)	10	3
4	Offset Miscellaneous Food Revenue	(573)	2	4
5	Offset Miscellaneous Office Supplies Revenue	(191)	21	5
6	Offset Chamber of Commerce Dues	(375)	20	6
7	Resident Flowers	(44)	43	7
8	Disallowed Special Events	(790)	43	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
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43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(22,204)		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%	\$ 3,663	\$ 3,663	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	60	60	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	27	27	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	2	2	4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	380	380	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	2,239	2,239	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	901	901	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	6,358	6,358	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%	1,110	1,110	10
11	V	17 Administrative	126,000	Petersen Health Care, Inc.	100.00%	28,518	(97,482)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	3,219	3,219	12
13	V							13
14	Total		\$ 126,000			\$ 46,477	\$ * (79,523)	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%	\$ 993	\$	993	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	35,787		35,787	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	217		217	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	218		218	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	2,818		2,818	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	172		172	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	10,188		10,188	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	3,899		3,899	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	2,743		2,743	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	523		523	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%	446		446	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		\$			\$ 58,004	\$ *	58,004	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1 Dietary	\$	Petersen Health Operations, LLC	100.00%	\$ 0	\$	15	
16	V	2 Food		Petersen Health Operations, LLC	100.00%	3	3	16	
17	V	3 Housekeeping		Petersen Health Operations, LLC	100.00%	0		17	
18	V	4 Laundry		Petersen Health Operations, LLC	100.00%	0		18	
19	V	5 Utilities		Petersen Health Operations, LLC	100.00%	0		19	
20	V	6 Maintenance		Petersen Health Operations, LLC	100.00%	1,125	1,125	20	
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	347	347	21	
22	V	10 Nursing and Medical Records		Petersen Health Operations, LLC	100.00%	1	1	22	
23	V	12 Social Services		Petersen Health Operations, LLC	100.00%	9	9	23	
24	V	17 Administrative		Petersen Health Operations, LLC	100.00%	2,237	2,237	24	
25	V	19 Professional Services		Petersen Health Operations, LLC	100.00%	2,886	2,886	25	
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Operations, LLC	100.00%	49	49	26	
27	V	21 Clerical and General Office		Petersen Health Operations, LLC	100.00%	5,536	5,536	27	
28	V	22 Employee Benefits & Payroll		Petersen Health Operations, LLC	100.00%	0		28	
29	V	23 Inservice Training & Education		Petersen Health Operations, LLC	100.00%	15	15	29	
30	V	24 Travel and Seminar		Petersen Health Operations, LLC	100.00%	15	15	30	
31	V	25 Other Admin. Staff Transport.		Petersen Health Operations, LLC	100.00%	5,207	5,207	31	
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Operations, LLC	100.00%	0		32	
33	V	27 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	1,581	1,581	33	
34	V	30 Depreciation		Petersen Health Operations, LLC	100.00%	1,279	1,279	34	
35	V	32 Interest		Petersen Health Operations, LLC	100.00%	10,442	10,442	35	
36	V	33 Real Estate Taxes		Petersen Health Operations, LLC	100.00%	0		36	
37	V	34 Rent-Facility and Grounds		Petersen Health Operations, LLC	100.00%	0		37	
38	V	35 Rent-Equipment & Vehicles		Petersen Health Operations, LLC	100.00%	0		38	
39	Total		\$			\$ 30,732	\$ *	30,732	39

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

Facility Name & ID Number South Elgin Rehabilitation & Health Care C # 0047621 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	1,800,156	0.86	1.43	Salary	28,518	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	\$ 28,518		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 South Elgin Rehabilitation & Health Care Center # 0047621 Report Period Beginning: 1/1/2008 Ending: 2/31/2008

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Petersen Health Care, Inc.
 Street Address 830 W. Trailcreek Drive
 City / State / Zip Code Peoria, IL 61614
 Phone Number (309) 691-8113
 Fax Number (309) 691-8622

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,413,604	69	\$ 251,260	\$ 250,687	20,610	\$ 3,663	1
2	2	Food	Resident Days	1,413,604	69	4,125	0	20,610	60	2
3	3	Housekeeping	Resident Days	1,413,604	69	1,859	0	20,610	27	3
4	4	Laundry	Resident Days	1,413,604	69	110	0	20,610	2	4
5	5	Utilities	Resident Days	1,413,604	69	26,036	0	20,610	380	5
6	6	Maintenance	Resident Days	1,413,604	69	153,551	100,245	20,610	2,239	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	61,774	0	20,610	901	7
8	10	Nursing and Medical Records	Resident Days	1,413,604	69	436,084	432,530	20,610	6,358	8
9	10A	Therapy	Resident Days	1,413,604	69	0	0	20,610	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	76,136	0	20,610	1,110	10
11	17	Administrative	Resident Days	1,413,604	69	1,955,999	1,956,000	20,610	28,518	11
12	19	Professional Services	Resident Days	1,413,604	69	220,762	0	20,610	3,219	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,413,604	69	68,094	0	20,610	993	13
14	21	Clerical and General Office	Resident Days	1,413,604	69	2,454,596	2,013,896	20,610	35,787	14
15	23	Inservice Training & Education	Resident Days	1,413,604	69	14,912	0	20,610	217	15
16	24	Travel and Seminar	Resident Days	1,413,604	69	14,938	0	20,610	218	16
17	25	Other Admin. Staff Transport.	Resident Days	1,413,604	69	193,264	0	20,610	2,818	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,413,604	69	11,767	0	20,610	172	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	698,810	0	20,610	10,188	19
20	30	Depreciation	Resident Days	1,413,604	69	267,426	0	20,610	3,899	20
21	32	Interest	Resident Days	1,413,604	69	188,107	0	20,610	2,743	21
22	33	Real Estate Taxes	Resident Days	1,413,604	69	35,872	0	20,610	523	22
23	34	Rent-Facility and Grounds	Resident Days	1,413,604	69	0	0	20,610	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,413,604	69	30,580	0	20,610	446	24
25	TOTALS					\$ 7,166,062	\$ 4,753,358		\$ 104,481	25

Facility Name & ID Number South Elgin Rehabilitation & Health Care Center # 0047621 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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	419,957	23	\$	20,610	\$	1	
2	2	Food	Resident Days	419,957	23	68	20,610	3	2	
3	3	Housekeeping	Resident Days	419,957	23		20,610		3	
4	4	Laundry	Resident Days	419,957	23		20,610		4	
5	5	Utilities	Resident Days	419,957	23		20,610		5	
6	6	Maintenance	Resident Days	419,957	23	22,929	10,000	20,610	1,125	6
7	7	Mgmt. Allocation of Benefits	Resident Days	419,957	23	7,067		20,610	347	7
8	10	Nursing and Medical Records	Resident Days	419,957	23	6		20,610	1	8
9	12	Social Services	Resident Days	419,957	23	187		20,610	9	9
10	17	Administrative	Resident Days	419,957	23	45,582	45,582	20,610	2,237	10
11	19	Professional Services	Resident Days	419,957	23	58,812		20,610	2,886	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	419,957	23	997		20,610	49	12
13	21	Clerical and General Office	Resident Days	419,957	23	112,798		20,610	5,536	13
14	22	Employee Benefits & Payroll	Resident Days	419,957	23			20,610		14
15	23	Inservice Training & Education	Resident Days	419,957	23	299		20,610	15	15
16	24	Travel and Seminar	Resident Days	419,957	23	296		20,610	15	16
17	25	Other Admin. Staff Transport.	Resident Days	419,957	23	106,105		20,610	5,207	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	419,957	23			20,610		18
19	27	Mgmt. Allocation of Benefits	Resident Days	419,957	23	32,211		20,610	1,581	19
20	30	Depreciation	Resident Days	419,957	23	26,070		20,610	1,279	20
21	32	Interest	Resident Days	419,957	23	212,765		20,610	10,442	21
22	33	Real Estate Taxes	Resident Days	419,957	23			20,610		22
23	34	Rent-Facility and Grounds	Resident Days	419,957	23			20,610		23
24	35	Rent-Equipment & Vehicles	Resident Days	419,957	23			20,610		24
25	TOTALS					\$ 626,192	\$ 55,582		\$ 30,732	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Bank of America		X	Mortgage	Varies	1/19/07	\$ 750,000	\$ 736,436	12/31/13	Varies	\$ 48,670	1								
2												2								
3							Interest Income Offset				(18)	3								
4							Home Office Allocation-PHC				2,743	4								
5							Home Office Allocation-PHO				10,442	5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related						\$ 750,000	\$ 736,436			\$ 61,837	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 750,000	\$ 736,436			\$ 61,837	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.		\$	59,000	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	\$	56,174	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(2,826)	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	58,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. Home Office Allocation			523	
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.		\$	55,697	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	_____	8
	2004	_____	9
	2005	54,760	10
	2006	56,994	11
	2007	56,174	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 South Elgin Rehabilitation & Health Care Center COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0047621

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>06-34-226-014</u>	<u>Long-Term Care Facility</u>	\$ <u>56,174.26</u>	\$ <u>56,174.26</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>56,174.26</u>	\$ <u>56,174.26</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: 15,169 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>131,116</u>	<u>2005</u>	<u>\$ 467,500</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	131,116		\$ 467,500	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	93	2005	1970	\$ ***	\$		\$	\$	\$
5									
6									
7									
8									
Improvement Type**									
9	Wheelchair		2006	15,515		25	621	621	1,552
10	Backflow Prevention		2006	14,325		25	573	573	1,433
11	Walls		2006	3,550		25	142	142	355
12	7 Rooms-Floor Replacement, Painting, Wallpaper, Trim Labor		2007	10,400		20	520	520	780
13	7 Rooms-Floor Tile, Sink, Supplies, Paint, Wallpaper		2007	5,100		20	255	255	383
14	Fire Sprinkler System Repair		2008	2,580		15	86	86	86
15	Dry Pipe Valve Accelerator Replacement		2008	8,436		15	281	281	281
16	Sprinkler System Repairs		2008	5,156		15	172	172	172
17	Water Line Repairs		2008	6,969		15	232	232	232
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28	*** Note:								
29	Facility was purchased as part of a multi-facility								
30	sale. For purposes of allocating the purchase								
31	price, appraisers valued the building and land								
32	at the value of the bare land only. The allocated								
33	amount appears on page 11 (Sch XI (A) line 1, column 4).								
34									
35									
36									

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47			2,488			(2,488)		47
48								48
49								49
50		716			46	46		50
51		10,701			257	257		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		\$ 83,448	\$ 2,488		\$ 3,185	\$ 697	\$ 5,274	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	\$ 158,626	\$ 26,252	\$ 21,256	\$ (4,996)	7-10 yrs.	\$ 64,922	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Home Office Allocation			4,875	4,875			74
75	TOTALS	\$ 158,626	\$ 26,252	\$ 26,131	\$ (121)		\$ 64,922	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)	\$ 709,574	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 28,740	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 29,316	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 576	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 70,196	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: \$ 21,861 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	2006 Ford E350	\$ 581.00	\$ 21,970	17
18					18
19					19
20					20
21	TOTAL		\$ 581.00	\$ 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.

South Elgin Rehabilitation & Health Care Center

0047621

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	\$ 16,298
Dishwasher	590
Laundry Equipment	303
Copier	4,224
Home Office Allocation	446
	<u>21,861</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		Contract	Total
		1 Drop-outs	2 Completed		
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(3)	hrs	\$	11,145	\$ 167,171	\$	11,145	\$ 167,171	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		353	5,294		353	5,294	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		18,781	281,711		18,781	281,711	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				85,305		85,305	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Respiratory Therapy</u>	10A(3)			7	100		7	100	12
13	Other (specify): _____									13
14	TOTAL			\$	30,286	\$ 454,276	\$ 85,305	30,286	\$ 539,581	14

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

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 514,640	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 514,640	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	308,324	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)	\$ 308,324	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)	\$ 822,964	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	\$ 2,803,053	1
2	Discounts and Allowances for all Levels	104,396	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,907,449	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	666,037	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 666,037	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	573	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	135,337	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	14,585	20
21	Other Medical Services	3,991	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 154,486	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	18	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 18	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Revenue</u>	4,812	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,812	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,732,802	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	585,498	31
32	Health Care	1,822,548	32
33	General Administration	563,345	33
	B. Capital Expense		
34	Ownership	175,969	34
	C. Ancillary Expense		
35	Special Cost Centers	227,708	35
36	Provider Participation Fee	49,410	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,424,478	40
41	Income before Income Taxes (line 30 minus line 40)**	308,324	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 308,324	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 **South Elgin Rehabilitation & Health Care Center**

0047621

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	2,166	2,202	\$ 74,114	\$ 33.66	1
2	Assistant Director of Nursing	273	273	8,327	30.50	2
3	Registered Nurses	13,615	14,022	425,184	30.32	3
4	Licensed Practical Nurses	3,736	3,819	101,392	26.55	4
5	CNAs & Orderlies	34,797	35,584	393,871	11.07	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,080	2,080	28,811	13.85	9
10	Activity Assistants	305	305	2,378	7.80	10
11	Social Service Workers	4,160	4,160	79,730	19.17	11
12	Dietician					12
13	Food Service Supervisor	1,521	1,529	21,005	13.74	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,883	10,204	91,397	8.96	15
16	Dishwashers					16
17	Maintenance Workers	2,002	2,053	26,931	13.12	17
18	Housekeepers	16,207	19,742	142,427	7.21	18
19	Laundry	1,389	1,444	11,165	7.73	19
20	Administrator	2,080	2,080	80,422	38.66	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,950	2,098	31,696	15.11	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	1,560	1,600	26,895	16.81	31
32	Other Health C: Care Plan Coord.	2,703	2,731	86,553	31.69	32
33	Other(specify) <u>Marketing</u>	1,056	1,088	15,402	14.16	33
34	TOTAL (lines 1 - 33)	101,483	107,014	\$ 1,647,700 *	\$ 15.40	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	87 hrs.	\$ 5,368	1(3)	35
36	Medical Director	Monthly	16,800	9(3)	36
37	Medical Records Consultant	Monthly	1,080	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,100	10(3)	39
40	Physical Therapy Consultant	3 Visits	50	10A(3)	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)		\$ 24,398		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

South Elgin Rehabilitation & Health Care Center

0047621

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)		4,580

Home Office Allocation

Heyl, Royster, Voelker & Allen	Legal	235
GoffWilson, P.A.	Legal	391
Ginoli & Company	Accountants	3,269
RSM McGladrey	Accountants	9
Miscellaneous Vendors	Computer Services	46
Emdeon Business Services	Computer Services	63
Advanced Answers on Demand	Computer Services	740
Access 2 Go	Computer Services	218
Ivans	Computer Services	505
Kemper Technology	Computer Services	400
VisionShare	Computer Services	43
Logmein	Computer Services	31
Comm Net Communiations	Computer Services	11
Charter Communications	Computer Services	9
Advanced System Designs	Computer Services	14
Consolidated Communications	Computer Services	9
Miscellaneous Vendors	Miscellaneous	112

Total (agree to Schedule V, line 19, column 8)		<u>10,685</u>
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South Elgin Rehabilitation & Health Care Center

0047621

Period Beginning 1/1/2008

Period End 12/31/2008

XIX. SUPPORT SCHEDULES

Schedule 21B

A. Administrative Salaries

Name	Function	Ownership %	Amount
Renee Bogard	Administrator	0	39,875
Kathleen Copeland	Administrator	0	29,055
Mary Karson	Administrator	0	11,492
	Total		<u>80,422</u>

Facility Name & ID Number South Elgin Rehabilitation & Health Care Center# 0047621Report Period Beginning: 1/1/2008Ending: 12/31/2008**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. 2,120 -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. \$ 23,312 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. \$ 49,410
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. \$ 573
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ No
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? Adequate records have been maintained.
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. \$ No
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli & Company The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit currently in progress
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees