

Facility Name & ID Number Watseka Rehabilitation & Health Care Center

0046847 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	123	Skilled (SNF)	123	45,018	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	123	TOTALS	123	45,018	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	3 Private Pay	4 Other	4 Total	
8	SNF	24,626	4,714	4,327	33,667	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,626	4,714	4,327	33,667	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.79%

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 1/1/2005

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

YES Date 1/1/2005 NO

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

YES NO If YES, enter number of beds certified 123 and days of care provided 4,007

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 Watseka Rehabilitation & Health Care Center # 0046847 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	161,462	19,764		181,226		181,226	5,984	187,210		1
2	Food Purchase		177,445		177,445		177,445	(2,384)	175,061		2
3	Housekeeping	170,409	17,362		187,771		187,771	44	187,815		3
4	Laundry	245	16,467		16,712		16,712	3	16,715		4
5	Heat and Other Utilities			165,173	165,173		165,173	620	165,793		5
6	Maintenance	37,239	16,144	27,401	80,784		80,784	5,198	85,982		6
7	Other (specify):* <u>Home Off. Ben. All.</u>							1,471	1,471		7
8	TOTAL General Services	369,355	247,182	192,574	809,111		809,111	10,936	820,047		8
	B. Health Care and Programs										
9	Medical Director			8,400	8,400		8,400		8,400		9
10	Nursing and Medical Records	1,152,766	81,651	344,951	1,579,368		1,579,368	5,423	1,584,791		10
10a	Therapy	1,400		298,352	299,752		299,752		299,752		10a
11	Activities	80,231	3,797	305	84,333		84,333		84,333		11
12	Social Services	27,607	250	1,589	29,446		29,446		29,446		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Off. Ben. All.</u>							1,813	1,813		15
16	TOTAL Health Care and Programs	1,262,004	85,698	653,597	2,001,299		2,001,299	7,236	2,008,535		16
	C. General Administration										
17	Administrative	54,958		158,000	212,958		212,958	(111,415)	101,543		17
18	Directors Fees										18
19	Professional Services			6,885	6,885		6,885	12,261	19,146		19
20	Dues, Fees, Subscriptions & Promotions			11,643	11,643		11,643	3,865	15,508		20
21	Clerical & General Office Expenses	33,759	8,867	22,328	64,954		64,954	67,364	132,318		21
22	Employee Benefits & Payroll Taxes			243,045	243,045		243,045	1,171	244,216		22
23	Inservice Training & Education			448	448		448	355	803		23
24	Travel and Seminar			275	275		275	488	763		24
25	Other Admin. Staff Transportation			16,987	16,987		16,987	7,612	24,599		25
26	Insurance-Prop.Liab.Malpractice			27,755	27,755		27,755	2,109	29,864		26
27	Other (specify):* <u>Home Off. Ben. All.</u>							16,643	16,643		27
28	TOTAL General Administration	88,717	8,867	487,366	584,950		584,950	453	585,403		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,720,076	341,747	1,333,537	3,395,360		3,395,360	18,625	3,413,985		29

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

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

Facility Name & ID Number

Watseka Rehabilitation & Health Care Center

#0046847

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			203,831	203,831		203,831	28,737	232,568			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			189,054	189,054		189,054	38,299	227,353			32
33	Real Estate Taxes			76,646	76,646		76,646	854	77,500			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			23,098	23,098		23,098	906	24,004			35
36	Other (specify):*											36
37	TOTAL Ownership			492,629	492,629		492,629	68,796	561,425			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		130,728		130,728		130,728		130,728			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			67,530	67,530		67,530		67,530			42
43	Other (specify):* Non-allowable Cost	30,228	731	400,171	431,130		431,130	(431,130)				43
44	TOTAL Special Cost Centers	30,228	131,459	467,701	629,388		629,388	(431,130)	198,258			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,750,304	473,206	2,293,867	4,517,377		4,517,377	(343,709)	4,173,668			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	(2,482)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,907)	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	(1,676)	30		9
10	Interest and Other Investment Income	(49)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(173)	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	(25,992)	43		18
19	Entertainment				19
20	Contributions	(275)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(357,090)	43		24
25	Fund Raising, Advertising and Promotional	(34,656)	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	(13,379)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (440,679)		\$	30

BHF USE ONLY							
48		49		50		51	
							52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	96,970	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 96,970		36
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (343,709)		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

Watseka Rehabilitation & Health Care Center

ID# 0046847

Report Period Beginning: 1/1/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (4,800)	43	1
2	X-Rays-Part A	(2,093)	43	2
3	Disallowed Special Events	6	43	3
4	Resident Flowers	(1,150)	43	4
5	Offset Miscellaneous Office Supplies Revenue	(135)	21	5
6	Offset Chamber of Commerce Dues	(244)	20	6
7	Offset Miscellaneous Nursing Supplies Revenue	(4,963)	10	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
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31				31
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36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(13,379)		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:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 5,984	\$ 5,984	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	98	98	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	44	44	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	3	3	4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	620	620	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	3,657	3,657	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,471	1,471	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	10,386	10,386	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%	1,813	1,813	10
11	V	17 Administrative	158,000	Petersen Health Care, Inc.	100.00%	46,585	(111,415)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	5,258	5,258	12
13	V							13
14	Total		\$ 158,000			\$ 75,919	\$ * (82,081)	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%	\$ 1,622	\$	1,622	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	58,460		58,460	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	355		355	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	356		356	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	4,603		4,603	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	280		280	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	16,643		16,643	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	6,369		6,369	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	4,480		4,480	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	854		854	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%	728		728	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		\$			\$ 94,750	\$ *	94,750	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 Care II, Inc.	100.00%	\$ 0	\$	15	
16	V	2 Food		Petersen Health Care II, Inc.	100.00%	0		16	
17	V	3 Housekeeping		Petersen Health Care II, Inc.	100.00%	0		17	
18	V	4 Laundry		Petersen Health Care II, Inc.	100.00%	0		18	
19	V	5 Utilities		Petersen Health Care II, Inc.	100.00%	0		19	
20	V	6 Maintenance		Petersen Health Care II, Inc.	100.00%	1,541	1,541	20	
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	100.00%	0		21	
22	V	10 Nursing and Medical Records		Petersen Health Care II, Inc.	100.00%	0		22	
23	V	15 Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	100.00%	0		23	
24	V	17 Administrative		Petersen Health Care II, Inc.	100.00%	0		24	
25	V	19 Professional Services		Petersen Health Care II, Inc.	100.00%	7,003	7,003	25	
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Care II, Inc.	100.00%	2,487	2,487	26	
27	V	21 Clerical and General Office		Petersen Health Care II, Inc.	100.00%	9,039	9,039	27	
28	V	22 Employee Benefits & Payroll		Petersen Health Care II, Inc.	100.00%	1,171	1,171	28	
29	V	23 Inservice Training & Education		Petersen Health Care II, Inc.	100.00%	0		29	
30	V	24 Travel and Seminar		Petersen Health Care II, Inc.	100.00%	132	132	30	
31	V	25 Other Admin. Staff Transport.		Petersen Health Care II, Inc.	100.00%	3,009	3,009	31	
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care II, Inc.	100.00%	1,829	1,829	32	
33	V	27 Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	100.00%	0		33	
34	V	30 Depreciation		Petersen Health Care II, Inc.	100.00%	24,044	24,044	34	
35	V	32 Interest		Petersen Health Care II, Inc.	100.00%	33,868	33,868	35	
36	V	33 Real Estate Taxes		Petersen Health Care II, Inc.	100.00%	0		36	
37	V	34 Rent-Facility and Grounds		Petersen Health Care II, Inc.	100.00%	0		37	
38	V	35 Rent-Equipment & Vehicles		Petersen Health Care II, Inc.	100.00%	178	178	38	
39	Total		\$			\$ 84,301	\$ *	84,301	39

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

Facility Name & ID Number Watseka Rehabilitation & Health Care Cent # 0046847 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	1,782,089	1.4	2.33	Salary	\$ 46,585	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	\$ 46,585		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 Watseka Rehabilitation & Health Care Center

0046847

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	33,667	\$ 5,984	1
2	2	Food	Resident Days	1,413,604	69	4,125	0	33,667	98	2
3	3	Housekeeping	Resident Days	1,413,604	69	1,859	0	33,667	44	3
4	4	Laundry	Resident Days	1,413,604	69	110	0	33,667	3	4
5	5	Utilities	Resident Days	1,413,604	69	26,036	0	33,667	620	5
6	6	Maintenance	Resident Days	1,413,604	69	153,551	100,245	33,667	3,657	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	61,774	0	33,667	1,471	7
8	10	Nursing and Medical Records	Resident Days	1,413,604	69	436,084	432,530	33,667	10,386	8
9	10A	Therapy	Resident Days	1,413,604	69	0	0	33,667	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	76,136	0	33,667	1,813	10
11	17	Administrative	Resident Days	1,413,604	69	1,955,999	1,956,000	33,667	46,585	11
12	19	Professional Services	Resident Days	1,413,604	69	220,762	0	33,667	5,258	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,413,604	69	68,094	0	33,667	1,622	13
14	21	Clerical and General Office	Resident Days	1,413,604	69	2,454,596	2,013,896	33,667	58,460	14
15	23	Inservice Training & Education	Resident Days	1,413,604	69	14,912	0	33,667	355	15
16	24	Travel and Seminar	Resident Days	1,413,604	69	14,938	0	33,667	356	16
17	25	Other Admin. Staff Transport.	Resident Days	1,413,604	69	193,264	0	33,667	4,603	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,413,604	69	11,767	0	33,667	280	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	698,810	0	33,667	16,643	19
20	30	Depreciation	Resident Days	1,413,604	69	267,426	0	33,667	6,369	20
21	32	Interest	Resident Days	1,413,604	69	188,107	0	33,667	4,480	21
22	33	Real Estate Taxes	Resident Days	1,413,604	69	35,872	0	33,667	854	22
23	34	Rent-Facility and Grounds	Resident Days	1,413,604	69	0	0	33,667	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,413,604	69	30,580	0	33,667	728	24
25	TOTALS					\$ 7,166,062	\$ 4,753,358		\$ 170,669	25

Facility Name & ID Number Watseka Rehabilitation & Health Care Center

0046847

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 II, 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	331,413	13	\$	33,667	\$	1
2	2	Food	Resident Days	331,413	13		33,667		2
3	3	Housekeeping	Resident Days	331,413	13		33,667		3
4	4	Laundry	Resident Days	331,413	13		33,667		4
5	5	Utilities	Resident Days	331,413	13		33,667		5
6	6	Maintenance	Resident Days	331,413	13	15,163	33,667	1,541	6
7	7	Mgmt. Allocation of Benefits	Resident Days	331,413	13		33,667		7
8	10	Nursing and Medical Records	Resident Days	331,413	13		33,667		8
9	15	Mgmt. Allocation of Benefits	Resident Days	331,413	13		33,667		9
10	17	Administrative	Resident Days	331,413	13		33,667		10
11	19	Professional Services	Resident Days	331,413	13	68,939	33,667	7,003	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	331,413	13	24,482	33,667	2,487	12
13	21	Clerical and General Office	Resident Days	331,413	13	88,982	33,667	9,039	13
14	22	Employee Benefits & Payroll	Resident Days	331,413	13	11,527	33,667	1,171	14
15	23	Inservice Training & Education	Resident Days	331,413	13		33,667		15
16	24	Travel and Seminar	Resident Days	331,413	13	1,299	33,667	132	16
17	25	Other Admin. Staff Transport.	Resident Days	331,413	13	29,621	33,667	3,009	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	331,413	13	18,001	33,667	1,829	18
19	27	Mgmt. Allocation of Benefits	Resident Days	331,413	13		33,667		19
20	30	Depreciation	Resident Days	331,413	13	236,686	33,667	24,044	20
21	32	Interest	Resident Days	331,413	13	333,393	33,667	33,868	21
22	33	Real Estate Taxes	Resident Days	331,413	13		33,667		22
23	34	Rent-Facility and Grounds	Resident Days	331,413	13		33,667		23
24	35	Rent-Equipment & Vehicles	Resident Days	331,413	13	1,756	33,667	178	24
25	TOTALS					\$ 829,849	\$	\$ 84,301	25

Facility Name & ID Number Watseka Rehabilitation & Health Care Cente# 0046847

Report Period Beginning:

1/1/2008

Ending:

12/31/2008**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE****A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1	Name of Lender	2		3	4	5	6		7	8	9	10					
		Related**					Monthly Payment Required	Date of Note					Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
A. Directly Facility Related																	
Long-Term																	
1	US Bank		X	Mortgage	Varies	1/4/2005	\$ 2,960,000	\$ 2,653,760	12/18/2011	0.0690	\$ 187,964	1					
2												2					
3							Interest Income Offset				(49)	3					
4							Home Office Allocation-PHC				4,480	4					
5							Home Office Allocation-PHC II				33,868	5					
Working Capital																	
6												6					
7												7					
8												8					
9	TOTAL Facility Related						\$ 2,960,000	\$ 2,653,760			\$ 226,263	9					
B. Non-Facility Related*																	
10							Amortization of Loan Cost				1,090	10					
11												11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$ 1,090	14					
15	TOTALS (line 9+line14)						\$ 2,960,000	\$ 2,653,760			\$ 227,353	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.		\$	76,000	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	\$	75,146	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(854)	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	77,500	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. Home Office Allocation			854	
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.		\$	77,500	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003		8
	2004	37,500	9
	2005	73,998	10
	2006	73,444	11
	2007	75,146	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 Watseka Rehabilitation & Health Care Center COUNTY Iroquois

FACILITY IDPH LICENSE NUMBER 0046847

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>17-C-19-33-153-013</u>	<u>Long-Term Care Facility</u>	\$ <u>75,146.18</u>	\$ <u>75,146.18</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>75,146.18</u>	\$ <u>75,146.18</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: 28,000 B. General Construction Type: Exterior Brick & Block Frame Steel Number of Stories 1

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

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

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

N/A

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>28,000</u>	<u>2005</u>	<u>\$ 120,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	28,000		\$ 120,000	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	123	2005	1976	\$ 2,511,949	\$	30	\$ 83,732	\$ 83,732	\$ 334,927	4
5										5
6										6
7	Home Office Allocation									7
8										8
Improvement Type**										
9	Parking lots, sidewalks & landscaping		2005	534,029		15	35,602	35,602	142,407	9
10	Sidewalks		2006	6,600		15	440	440	1,100	10
11	Roof		2007	7,678		15	512	512	768	11
12	Roof Repair		2008	3,276		39	42	42	42	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				83,732			(83,732)		28
29	Building Improvement Booked				36,408			(36,408)		29
30										30
31										31
32	2008-Home Office Allocation-Land Improvements			1,170			75	75		32
33	2008-Home Office Allocation-Building Improvements			17,481			419	419		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)		\$ 3,082,183	\$ 120,140		\$ 120,822	\$ 682	\$ 479,244	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	\$ 767,350	\$ 79,223	\$ 76,735	\$ (2,488)	5-10 yrs.	\$ 299,691	71
72	Current Year Purchases	11,952	468	598	130	10 yrs.	598	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			30,413	30,413			74
75	TOTALS	\$ 779,302	\$ 79,691	\$ 107,746	\$ 28,055		\$ 300,289	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	Bus		2005	\$ 20,000	\$ 4,000	\$ 4,000	\$	5	\$ 16,000	76
77										77
78										78
79										79
80	TOTALS			\$ 20,000	\$ 4,000	\$ 4,000	\$		\$ 16,000	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)	\$ 4,001,485	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 203,831	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 232,568	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 28,737	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 795,533	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? YES NO

If NO, see instructions.

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

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

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

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

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

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ 24,004 Description: See Attached Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2009 \$ _____

13. _____ /2010 \$ _____

14. _____ /2011 \$ _____

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

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

Watseka Rehabilitation & Health Care Center

0046847

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	\$ 16,328
Copier	6,770
Home Office Allocation	906
	<u>24,004</u>

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$		\$ 139,325	\$		\$ 139,325	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs			1,636			1,636	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(1,3)	185 hrs	1,400		157,391		185	158,791	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				130,728		130,728	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$ 1,400		\$ 298,352	\$ 130,728	185	\$ 430,480	14

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

Facility Name & ID Number Watseka Rehabilitation & Health Care Center

0046847

Report Period Beginning: 1/1/2008

Ending: 12/31/2008

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2008

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 64,374	\$ 64,374	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>N/A</u>)	1,125,134	1,125,134	3
4	Supply Inventory (priced at <u> </u>)			4
5	Short-Term Investments			5
6	Prepaid Insurance	32,216	32,216	6
7	Other Prepaid Expenses	14,692	14,692	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Employee Education Loans</u>	249	249	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,236,665	\$ 1,236,665	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	660,629	120,000	13
14	Buildings, at Historical Cost	2,511,949	2,529,430	14
15	Leasehold Improvements, at Historical Cost	10,955	552,753	15
16	Equipment, at Historical Cost	799,302	799,302	16
17	Accumulated Depreciation (book methods)	(799,064)	(795,533)	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>Goodwill/Loan Costs</u>)	261,121	261,121	22
23	Other(specify): <u>A/R-Prior Owner</u>	3,863	3,863	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,448,755	\$ 3,470,936	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,685,420	\$ 4,707,601	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 905,617	\$ 905,617	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	113,307	113,307	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,016	4,016	31
32	Accrued Real Estate Taxes(Sch.IX-B)	77,500	77,500	32
33	Accrued Interest Payable	14,803	14,803	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	31,478	31,478	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,146,721	\$ 1,146,721	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,653,760	2,653,760	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,653,760	\$ 2,653,760	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,800,481	\$ 3,800,481	46
47	TOTAL EQUITY(page 18, line 24)	\$ 884,939	\$ 907,120	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,685,420	\$ 4,707,601	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 837,311	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 837,311	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	47,628	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)	\$ 47,628	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)	\$ 884,939	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Watseka Rehabilitation & Health Care Center# 0046847Report Period Beginning: 1/1/2008Ending: 12/31/2008**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	\$ 3,683,690	1
2	Discounts and Allowances for all Levels	168,593	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,852,283	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	469,945	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 469,945	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	2,482	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	209,472	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	19,946	20
21	Other Medical Services	5,730	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 237,630	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	49	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 49	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Revenue</u>	5,098	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 5,098	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,565,005	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	809,111	31
32	Health Care	2,001,299	32
33	General Administration	584,950	33
	B. Capital Expense		
34	Ownership	492,629	34
	C. Ancillary Expense		
35	Special Cost Centers	561,858	35
36	Provider Participation Fee	67,530	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,517,377	40
41	Income before Income Taxes (line 30 minus line 40)**	47,628	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 47,628	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 Watseka Rehabilitation & Health Care Center

0046847

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	1,588	1,588	\$ 38,334	\$ 24.14	1
2	Assistant Director of Nursing	2,080	2,080	46,511	22.36	2
3	Registered Nurses	3,343	3,403	90,638	26.63	3
4	Licensed Practical Nurses	14,918	15,636	312,276	19.97	4
5	CNAs & Orderlies	56,347	58,241	563,554	9.68	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	185	185	1,400	7.57	8
9	Activity Director	1,997	2,157	26,540	12.30	9
10	Activity Assistants	5,450	5,680	52,394	9.22	10
11	Social Service Workers	3,243	3,442	27,607	8.02	11
12	Dietician					12
13	Food Service Supervisor	2,227	2,227	25,978	11.67	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,488	16,941	135,484	8.00	15
16	Dishwashers					16
17	Maintenance Workers	2,987	3,083	37,239	12.08	17
18	Housekeepers	17,498	18,026	170,409	9.45	18
19	Laundry	44	44	245	5.57	19
20	Administrator	1,867	1,963	54,958	28.00	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	3,007	3,292	33,759	10.25	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	444	444	4,457	10.04	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Sch. PG20A</u>	6,897	7,157	128,521	17.96	33
34	TOTAL (lines 1 - 33)	140,610	145,589	\$ 1,750,304 *	\$ 12.02	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant			35
36	Medical Director	Monthly 8,400	9(3)	36
37	Medical Records Consultant	Monthly 1,800	10(3)	37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 1,100	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	Monthly 1,589	12(3)	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 12,889		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	3,802	\$ 216,077	10(3)	50
51	Licensed Practical Nurses	2,827	107,352	10(3)	51
52	Certified Nurse Assistants/Aides	699	18,204	10(3)	52
53	TOTAL (lines 50 - 52)	7,328	\$ 341,633		53

Watseka Rehabilitation & Health Care Center

0046847

Period Beginning 1/1/2008

Period End 12/31/2008

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	4,247	4,507	91,588	20.32
Marketing	2,080	2,080	30,228	14.53
Transportation	137	137	1,297	9.47
Alzheimer's Coord	433	433	5,408	12.49
TOTAL (lines 1 - 35)	<u>6,897</u>	<u>7,157</u>	<u>128,521</u>	

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				
Linda Harsbarger	Administrator	0	\$ 28,086	Workers' Compensation Insurance	\$ 78,193	IDPH License Fee	\$ 1,990				
Scott Mow	Administrator	0	26,872	Unemployment Compensation Insurance	31,364	Advertising: Employee Recruitment	2,959				
				FICA Taxes	131,048	Health Care Worker Background Check (Indicate # of checks performed)					
				Employee Health Insurance	(5,307)	Patient Background Checks	262 2,620				
				Employee Meals		Miscellaneous Licenses & Permits	240				
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Dues & Subscriptions	244				
				Employee Relations	8,918	IHCA Dues	3,590				
				Employee Retirement		Home Office Allocation	4,109				
				Employee Life Insurance							
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 54,958	TOTAL (agree to Schedule V, line 22, col.8)			\$ 244,216	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 15,508	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**			
Description			Amount	Description		Line #	Amount	Description		Amount	
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 158,000	N/A				Out-of-State Travel		\$	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 158,000	TOTAL				In-State Travel			
C. Professional Services				TOTAL				Seminar Expense			
Vendor/Payee	Type		Amount					Home Office Allocation		488	
E-Health Data Solutions	Computer Services		\$ 3,045					Entertainment Expense		()	
Mediacom	Computer Services		1,204					TOTAL (agree to Sch. V, line 24, col. 8)		\$ 763	
LTC Solutions	Computer Services		1,600								
Heyl, Royster, Voelker, & Allen	Legal Services		1,036								
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 6,885								

* Attach copy of IMRF notifications

**See instructions.

Watseka Rehabilitation & Health Care Center

0046847

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)		6,885

Home Office Allocation

Heyl, Royster, Voelker & Allen	Legal	191
GoffWilson, P.A.	Legal	638
U.S. Bank	Legal	1,114
Ginoli & Company	Accountants	5,610
RSM McGladrey	Accountants	15
U.S. Bank	Accountants	684
Miscellaneous Vendors	Computer Services	74
Emdeon Business Services	Computer Services	103
Advanced Answers on Demand	Computer Services	1,208
Access 2 Go	Computer Services	356
Ivans	Computer Services	992
Kemper Technology	Computer Services	654
VisionShare	Computer Services	70
Logmeln	Computer Services	50
Comm Net Communiations	Computer Services	18
Charter Communications	Computer Services	15
Advanced System Designs	Computer Services	23
Consolidated Communications	Computer Services	14
CDW	Computer Services	340
Miscellaneous Vendors	Miscellaneous	92

Total (agree to Schedule V, line 19, column 8)	<u>19,146</u>
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Watseka Rehabilitation & Health Care Center

0046847

Period Beginning 1/1/2008

Period End 12/31/2008

XIX. SUPPORT SCHEDULES

Schedule 21B

A. Administrative Salaries

Name	Function	Ownership %	Amount
Linda Hasbargen	Administrator	0	28,086
Scott Mow	Administrator	0	26,872
	Total		<u>54,958</u>

Facility Name & ID Number Watseka Rehabilitation & Health Care Center# 0046847Report 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. 3,590 -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. \$ 16,765 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. \$ 67,530
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. \$ 2,482
- (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