

Facility Name & ID Number Effingham Rehabilitation & Health Care Center

0047159 Report Period Beginning: 5/1/2005 Ending: 12/31/2005

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	62	Skilled (SNF)	62	15,190	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	62	TOTALS	62	15,190	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		2 Medicaid Recipient	3 Private Pay	4 Other		
8	SNF	6,412	2,767	1,303	10,482	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	6,412	2,767	1,303	10,482	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.01%

D. How many bed-hold days during this year were paid by the Department? 0 (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 5/1/2005

J. Was the facility purchased or leased after January 1, 1978?
YES Date 5/1/2005 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 16 and days of care provided 1,303

Medicare Intermediary Not yet determined

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year YES NO

Tax Year: 12/31/05 Fiscal Year: 12/31/05

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

STATE OF ILLINOIS

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Facility Name & ID Number Effingham Rehabilitation & Health Care Center # 0047159 Report Period Beginning: 5/1/2005 Ending: 12/31/2005

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
A. General Services											
1	Dietary	64,531	2,833		67,364		67,364	1,260	68,624		1
2	Food Purchase		43,916		43,916		43,916	(2,837)	41,079		2
3	Housekeeping	43,805	11,204		55,009		55,009	28	55,037		3
4	Laundry	14,379	7,361		21,740		21,740	2	21,742		4
5	Heat and Other Utilities			39,061	39,061		39,061	208	39,269		5
6	Maintenance	18,275	17,991	1,482	37,748		37,748	1,654	39,402		6
7	Other (specify):* Mgmt alloc. of benefits							360	360		7
8	TOTAL General Services	140,990	83,305	40,543	264,838		264,838	675	265,513		8
B. Health Care and Programs											
9	Medical Director			4,950	4,950		4,950		4,950		9
10	Nursing and Medical Records	312,845	35,380		348,225		348,225	2,086	350,311		10
10a	Therapy		51	102,262	102,313		102,313	1	102,314		10a
11	Activities	13,588	602	733	14,923		14,923		14,923		11
12	Social Services	13,735	120		13,855		13,855		13,855		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Mgmt alloc. of benefits							289	289		15
16	TOTAL Health Care and Programs	340,168	36,153	107,945	484,266		484,266	2,376	486,642		16
C. General Administration											
17	Administrative	34,817		20,000	54,817		54,817	(11,070)	43,747		17
18	Directors Fees										18
19	Professional Services			1,867	1,867		1,867	3,482	5,349		19
20	Dues, Fees, Subscriptions & Promotion			3,928	3,928		3,928	2,340	6,268		20
21	Clerical & General Office Expense	14,723	4,074	8,201	26,998		26,998	12,120	39,118		21
22	Employee Benefits & Payroll Tax			113,618	113,618		113,618	2,272	115,890		22
23	Inservice Training & Education							187	187		23
24	Travel and Seminars			176	176		176	257	433		24
25	Other Admin. Staff Transportation			1,738	1,738		1,738	1,105	2,843		25
26	Insurance-Prop.Liab.Malpractice			20,791	20,791		20,791	341	21,132		26
27	Other (specify):* Mgmt alloc. of benefits							2,563	2,563		27
28	TOTAL General Administration	49,540	4,074	170,319	223,933		223,933	13,597	237,530		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	530,698	123,532	318,807	973,037		973,037	16,648	989,685		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Effingham Rehabilitation & Health Care Center

#0047159

Report Period Beginning:

5/1/2005

Ending:

12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			25,420	25,420		25,420	5,581	31,001			30
31	Amortization of Pre-Op. & Org											31
32	Interest			46,376	46,376		46,376	5,107	51,483			32
33	Real Estate Taxes			29,171	29,171		29,171		29,171			33
34	Rent-Facility & Grounds							207	207			34
35	Rent-Equipment & Vehicle:			13,577	13,577		13,577	51	13,628			35
36	Other (specify): ³											36
37	TOTAL Ownership			114,544	114,544		114,544	10,946	125,490			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportatior											38
39	Ancillary Service Center:			221	221		221		221			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shop:											41
42	Provider Participation Fee			22,785	22,785		22,785		22,785			42
43	Other (specify): ³ Nonallowable Cost			23,057	23,057		23,057	(23,057)				43
44	TOTAL Special Cost Centers		221	45,842	46,063		46,063	(23,057)	23,006			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	530,698	123,753	479,193	1,133,644		1,133,644	4,537	1,138,181			45

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

**See Schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

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	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Program				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Room	(2,281)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patient				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	3,940	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refund				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(823)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transaction				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(159)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainer				22
23	Malpractice Insurance for Individual				23
24	Bad Debt	(14,774)	43		24
25	Fund Raising, Advertising and Promotion	(3,147)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employee				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Schedule 5A	(4,380)	var		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (21,624)		\$	30

OHF 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)	26,161		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 26,161		36
	(sum of SUBTOTALS)			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ 4,537		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		x	\$		38
39						39
40	Gift and Coffee Shop		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Effingham Rehabilitation & Health Care Center

Provider #: 0047159

5/1/2005 to 12/31/2005

Schedule 5A

VI. Adjustment Detail

Line 29 - Other

<u>Non-allowable expenses</u>	<u>Amount</u>	<u>Reference</u>
Misc. - Part A	(247)	43
Labs - Part A	(1,626)	43
Misc income offset	(96)	21
Food income offset	(2,011)	2
Special Events	(400)	21
Total	<u>(4,380)</u>	

SEE ACCOUNTANTS' COMPILATION REPORT

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 Peterson	100	See Attached Schedule 6A		See Attached Schedule 6A		

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	\$	Peteresen Health Care, Inc.	100.00%	\$ 1,260	\$ 1,260	1
2	V	2 Food		Peteresen Health Care, Inc.	100.00%	40	40	2
3	V	3 Housekeeping		Peteresen Health Care, Inc.	100.00%	28	28	3
4	V	4 Laundry		Peteresen Health Care, Inc.	100.00%	2	2	4
5	V	5 Utilities		Peteresen Health Care, Inc.	100.00%	192	192	5
6	V	6 Maintenance		Peteresen Health Care, Inc.	100.00%	1,654	1,654	6
7	V	7 Mgmt. Allocation of Benefits		Peteresen Health Care, Inc.	100.00%	360	360	7
8	V	10 Nursing and Medical Records		Peteresen Health Care, Inc.	100.00%	2,086	2,086	8
9	V	10A Therapy		Peteresen Health Care, Inc.	100.00%	1	1	9
10	V	15 Mgmt. Allocation of Benefits		Peteresen Health Care, Inc.	100.00%	289	289	10
11	V	17 Administrative	20,000	Peteresen Health Care, Inc.	100.00%	8,930	(11,070)	11
12	V	19 Professional Services		Peteresen Health Care, Inc.	100.00%	2,593	2,593	12
13	V	20 Due, Fees, Subs & Promos		Peteresen Health Care, Inc.	100.00%	1,180	1,180	13
14	Total		\$ 20,000			\$ 18,615	\$ *	(1,385) 14

* Total must agree with the amount recorded on line 34 of Schedule V1

Facility Name & ID Number Effingham Rehabilitation & Health Care Cente

0047159

Report Period Beginning: 5/1/2005

Ending: 12/31/2005

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	21 Clerical & General Office	\$	Petersen Health Care, Inc.	100.00%	\$ 11,522	\$ 11,522
16	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	187	187
17	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	257	257
18	V	25 Other Admin. Staff Transport		Petersen Health Care, Inc.	100.00%	934	934
19	V	26 Insurance-Prop.Liab.Malpractice		Petersen Health Care, Inc.	100.00%	341	341
20	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	2,563	2,563
21	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	1,641	1,641
22	V	32 Interest		Petersen Health Care, Inc.	100.00%	2,208	2,208
23	V	34 Rent - Facility & Grounds		Petersen Health Care, Inc.	100.00%	207	207
24	V	35 Rent - Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	51	51
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 38,526	\$ * 18,526

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Effingham Rehabilitation & Health Care Cente

0047159

Report Period Beginning: 5/1/2005

Ending: 12/31/2005

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	5 Utilities	\$	Petersen Health Care II, Inc	100.00%	\$ 16	\$ 16
16	V	19 Professional Services		Petersen Health Care II, Inc	100.00%	889	889
17	V	20 Dues, Fees, Subs & Promotions		Petersen Health Care II, Inc	100.00%	1,160	1,160
18	V	21 Clerical & General Office Expenses		Petersen Health Care II, Inc	100.00%	1,094	1,094
19	V	22 Employee Benefits		Petersen Health Care II, Inc	100.00%	1,406	1,406
20	V	25 Other Admin Staff Transport		Petersen Health Care II, Inc	100.00%	171	171
21	V	32 Interest		Petersen Health Care II, Inc	100.00%	2,899	2,899
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 7,635	\$ * 7,635

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

SEE ACCOUNTANTS' COMPILATION REPORT

Effingham Rehabilitation & Health Care Center

Provider #: 0047159
5/1/2005 to 12/31/2005

Schedule 6A

VII Related Parties - Page 6

Related Nursing Homes

City

In-State:

Aledo Rehabilitation & Health Care Center	Aledo, IL
Arcola Health Care Center	Arcola, IL
Arrow Wood Estates of Rock Falls	Rock Falls, IL
Aspen Rehab & Health Care	Silvis, IL
Batavia Rehabilitation & Health Care Center	Batavia, IL
Bement Health Care Center	Bement, IL
Benton Rehabilitation & Health Care Center	Benton, IL
Bloomington Rehabilitation & Health Care Center	Bloomington, IL
Casey Health Care Center	Casey, IL
Cisne Rehabilitation & Health Care Center	Cisne, IL
Countryview Care Center of Macomb	Macomb, IL
Countryview Terrace	Louisville, IL
Decatur Rehabilitation & Health Care Center	Decatur, IL
Eastside Health & Rehabilitation Center	Pittsfield, IL
Eastview Terrace	Sullivan, IL
Effingham Rehabilitation & Health Care Center	Effingham, IL
El Paso Health Care Center	El Paso, IL
Elgin Rehabilitation & Health Care Center	South Elgin, IL
Enfield Rehabilitation & Health Care Center	Enfield, IL
Flora Health Care Center	Flora, IL
Fondulac Rehabilitation & Health Care Center	East Peoria, IL
Havana Health Care Center	Havana, IL
Ironwood Estates of Sandwich	Sandwich, IL
Jonesboro Rehabilitation & Health Care Center	Jonesboro, IL
Kewanee Care Home	Kewanee, IL
McLeansboro Rehabilitation & Health Care Center	McLeansboro, IL
Newman Rehabilitation & Health Care Center	Newman, IL
North Aurora Care Center	Aurora, IL
Palm Terrace of Mattoon	Mattoon, IL
Prairie Rose Health Care Center	Pana, IL
Robings Manor Nursing Home	Brighton, IL
Rock Falls Rehabilitation & Health Care Center	Rock Falls, IL
Rosiclare Rehabilitation & Health Care Center	Rosiclare, IL
Royal Oaks Care Center	Kewanee, IL
Sandwich Rehabilitation & Health Care Center	Sandwich, IL
Shelbyville Rehabilitation & Health Care Center	Shelbyville, IL
Sheldon Health Care Center	Sheldon, IL
Sugar Creek Care Center	Watseka, IL
Sullivan Health Care Center	Sullivan, IL
Sunset Manor Nursing Home	Canton, IL
Timbercreek Rehabilitation & Health Care Center	Pekin, IL
Toulon Rehabilitation & Health Care Center	Toulon, IL
Tuscola Health Care Center	Tuscola, IL
Vandalia Rehabilitation & Health Care Center	Vandalia, IL
Watsseka Rehabilitation & Health Care Center	Watsseka, IL

Out-of-State:

Meadow Lawn Nursing Center	Davenport, IA
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Related Assisted Living

Kewanee Courtyard Estates	Kewanee, IL
Kewanee Courtyard Village	Kewanee, IL
Monmouth Courtyard Estates	Monmouth, IL
Riverview Estates of Havana	Havana, IL
Simple Blessings	Casey, IL

Other Related Business Entities

Petersen Health Care, Inc.	Peoria, IL	Management/Bookkeeping
Petersen Health Care II, Inc.	Peoria, IL	Management/Bookkeeping
Petersen Enterprises	Peoria, IL	Management/Bookkeeping
Petersen Health Systems	Peoria, IL	Management/Bookkeeping
Petersen Health Operations, L.L.C.	Peoria, IL	Management/Bookkeeping
RLP Senior Villages, Inc.	Peoria, IL	Management/Bookkeeping

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Effingham Rehabilitation & Health Care Ce # 0047159 Report Period Beginning: 5/1/2005 Ending: 12/31/2005

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	65.00	See Schedule 7A	1	1.25	Salary	\$ 8,930	L17,C8	1
2	Jifi C. Jacob	Owner	Owner	10.00	See Schedule 7B	0	0.00	Salary	1,133	L17, C8	2
3	Cindy S. White	Owner	Owner	10.00	See Schedule 7B	0	0.00	Salary	0	n/a	3
4	Jacque Whitley	Owner	Owner	10.00	See Schedule 7B	0	0.00	Salary	0	n/a	4
5	Amrit Jacob	Administrator	Administrative	0.00	See Schedule 7B	0	0.00	Salary	0	n/a	5
6	David Petersen	Owner	Owner	5.00		0	0.00		0	n/a	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 10,063		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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Effingham Rehabilitation & Health Care Center # 0047159 Report Period Beginning: 5/1/2005 Ending: 2/31/2005

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 West 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1 Dietary	Patient Days	683,169	46	\$ 82,166	\$ 81,693	10,482	\$ 1,261	1
2	2 Food	Patient Days	683,169	46	2,606		10,482	40	2
3	3 Housekeeping	Patient Days	683,169	46	1,857		10,482	28	3
4	4 Laundry	Patient Days	683,169	46	144		10,482	2	4
5	5 Utilities	Patient Days	683,169	46	12,513		10,482	192	5
6	6 Maintenance	Patient Days	683,169	46	107,775	81,080	10,482	1,654	6
7	7 Mgmt. Allocation of Benefits	Patient Days	683,169	46	23,459		10,482	360	7
8	10 Nursing and Medical Records	Patient Days	683,169	46	135,903	130,651	10,482	2,085	8
9	10A Therapy	Patient Days	683,169	46	88		10,482	1	9
10	15 Mgmt. Allocation of Benefits	Patient Days	683,169	46	18,830		10,482	289	10
11	17 Administrative	Patient Days	683,169	46	582,000	582,000	10,482	8,930	11
12	19 Professional Services	Patient Days	683,169	46	168,984		10,482	2,593	12
13	20 Dues, Fees, Subs & Promos	Patient Days	683,169	46	76,921		10,482	1,180	13
14	21 Clerical & General Office	Patient Days	683,169	46	750,958	577,218	10,482	11,522	14
15	23 Inservice Training & Education	Patient Days	683,169	46	12,208		10,482	187	15
16	24 Travel & Seminar	Patient Days	683,169	46	16,731		10,482	257	16
17	25 Other Admin. Staff Transport	Patient Days	683,169	46	60,875		10,482	934	17
18	26 Insurance-Prop.Liab.Malp.	Patient Days	683,169	46	22,218		10,482	341	18
19	27 Mgmt. Allocation of Benefits	Patient Days	683,169	46	167,067		10,482	2,563	19
20	30 Depreciation	Patient Days	683,169	46	106,965		10,482	1,641	20
21	32 Interest	Patient Days	683,169	46	143,934		10,482	2,208	21
22	34 Rent - Facility & Grounds	Patient Days	683,169	46	13,500		10,482	207	22
23	35 Rent - Equipment & Vehicles	Patient Days	683,169	46	3,305		10,482	51	23
24									24
25	TOTALS				\$ 2,511,007	\$ 1,452,642		\$ 38,526	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Effingham Rehabilitation & Health Care Center # 0047159 Report Period Beginning: 5/1/2005 Ending: 2/31/2005

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 West 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Patient Days	54,205	4	\$ 85	\$ 10,482	\$ 16	1
2	19	Professional Services	Patient Days	54,205	4	4,595	10,482	889	2
3	20	Dues, Fees, Subs & Promotions	Patient Days	54,205	4	5,997	10,482	1,160	3
4	21	Clerical & General Office Expenses	Patient Days	54,205	4	5,657	10,482	1,094	4
5	22	Employee Benefits	Patient Days	54,205	4	7,273	10,482	1,406	5
6	25	Other Admin Staff Transport	Patient Days	54,205	4	883	10,482	171	6
7	32	Interest	Patient Days	54,205	4	14,991	10,482	2,899	7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 39,481	\$	\$ 7,635	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Effingham Rehabilitation & Health Care Cen # 0047159 Report Period Beginning: 5/1/2005 Ending: 12/31/2005

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		8	9	10	
		Related**					Amount of Note					
	Name of Lender	YES	NO	Purpose of Loan	Monthly Payment Required	Date of Note	Original	Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	F & M Bank of Galesburg		X	Mortgage	Varies	5/6/2005	\$ 2,810,000	\$ 838,455	5/6/2008	0.0748	\$ 41,916	1
2	Georgia Commercial Mgmt, Inc		X	Second Mortgage	Varies	5/1/2005	80,000	80,000	5/1/2007	0.0800	3,780	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$ 2,890,000	\$ 918,455			\$ 45,696	9
	B. Non-Facility Related*											
10												10
11												11
12										Amortization of loan costs	680	12
13										Allocated from Home Office	5,107	13
14	TOTAL Non-Facility Related						\$	\$			\$ 5,787	14
15	TOTALS (line 9+line14)						\$ 2,890,000	\$ 918,455			\$ 51,483	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.) SEE ACCOUNTANTS' COMPILATION REPORT

** 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

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and t must accompany the cost report</p>			
1. Real Estate Tax accrual used on 2004 report.		\$ 36,288	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.)	2004	\$ 28,159	2
3. Under or (over) accrual (line 2 minus line 1).		\$ (8,129)	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 37,300	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. 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		\$ 29,171	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2000		8
	2001	24,877	9
	2002	25,705	10
	2003	26,514	11
	2004	28,159	12
FOR OHF USE ONLY			
	13	FROM R. E. TAX STATEMENT FOR 2004 \$	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 filec

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2004 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 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 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.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Effingham Rehabilitation & Health Care Center COUNTY EFFINGHAM

FACILITY IDPH LICENSE NUMBER 0047159

CONTACT PERSON REGARDING THIS REPORT Mark Peterson

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 2004 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 2004.

(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>03-11-019-025</u>	<u>Long Term Care Facility</u>	\$ <u>28,158.60</u>	\$ <u>28,158.60</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>28,158.60</u>	\$ <u>28,158.60</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 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Effingham Rehabilitation & Health Care Center

0047159 Report Period Beginning:

5/1/2005 Ending: 12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 21,644 B. General Construction Type: Exterior Brick Frame _____ 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 ground (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, et List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

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:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Patient Care	176,400	2005	\$ 50,000	1
2					2
3	TOTALS			\$ 50,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

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 OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	62	2005	1998	\$ 718,400	\$ 14,967	30	\$ 15,964	\$ 997	\$ 15,964	4
5										5
6										6
7	Allocated from Home Office	2005		10,445			196	196	196	7
8										8
Improvement Type**										
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	2005 Home Office Allocation - Land Improvements			604			19	19	19	25
26	2005 Home Office Allocation - Leasehold Improvements			17			1	1	1	26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

37	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	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)		\$ 729,466	\$ 14,967		\$ 16,180	\$ 1,213	\$ 16,180	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number: Effingham Rehabilitation & Health Care Cent # 0047159 Report Period Beginning: 5/1/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instruction

	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	\$	\$	\$	\$		\$	71
72	Current Year Purchases	209,074	10,453	13,396	2,943	10	13,396	72
73	Fully Depreciated Assets							73
74	Allocated from Home Office			1,425	1,425			74
75	TOTALS	209,074	10,453	14,821	4,368		13,396	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	N/A									77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Asset

	1	2	
	Reference	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)	\$ 988,540	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 25,420	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 31,001	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 5,581	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 29,576	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 1

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		<u>Allocated from Home Office</u>			<u>207</u>			5
6								6
7	TOTAL				\$ <u>207</u>			7

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. /2006 \$ _____
 13. /2007 \$ _____
 14. /2008 \$ _____

8. List separately any amortization of lease expense included on page 4, line 34. N/A
 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: \$ 13,628 Description: See attached schedule
 (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					18
19	<u>N/A</u>				19
20					20
21	TOTAL		\$	\$	21

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

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

Effingham Rehabilitation & Health Care Center

Provider #: 0047159

5/1/2005 to 12/31/2005

Schedule 14A

Line 16 - Rental Equipment Detail

<u>Description of Equipment</u>	<u>Amount</u>
Oxygen concentrator	2,022
Bed/pump/wheelchair	3,403
Bipaps	1,050
Pressure Pump	280
CPM	720
Mattress	3,012
Gas dryer	680
Dishwasher	324
Drain cleaner	12
Auger	55
Tools	19
Copy machine	2,000
Allocation from Home Office	51
Total	<u>13,628</u>

SEE ACCOUNTANTS' COMPILATION REPORT

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. 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			
		1	2	3	4
		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 Wage (c)				
6	Transportation				
7	Contractual Payment:				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefit;
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefit;
- (c) For in-house training programs only. Do not include fringe benefit;
- (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

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	

- (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.

SEE ACCOUNTANTS' COMPILATION REPORT

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	L10A, C3	hrs	\$	1,581	\$ 25,613	\$	1,581	\$ 25,613	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		822	14,927		822	14,927	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C2,C3	hrs		3,547	61,722	51	3,547	61,773	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Oxygen	L39, C2					221		221	13
14	TOTAL			\$	5,950	\$ 102,262	\$ 272	5,950	\$ 102,534	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 17

Facility Name & ID Number Effingham Rehabilitation & Health Care Center

0047159

Report Period Beginning: 5/1/2005

Ending:

12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2005

(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	\$ 500	\$ 500	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>None</u>)	407,246	407,246	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	1,394	1,394	6
7	Other Prepaid Expenses	4,262	4,262	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): _____			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 413,402	\$ 413,402	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	50,000	50,000	13
14	Buildings, at Historical Cost	718,400	728,845	14
15	Leasehold Improvements, at Historical Cost		621	15
16	Equipment, at Historical Cost	209,074	209,074	16
17	Accumulated Depreciation (book methods)	(25,421)	(29,576)	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): _____			22
23	Other(specify): <u>Loan Costs</u>	2,387	2,387	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 954,440	\$ 961,351	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,367,842	\$ 1,374,753	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 203,001	\$ 203,001	26
27	Officer's Accounts Payable	107	107	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	26,372	26,372	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	37,300	37,300	32
33	Accrued Interest Payable	2,585	2,585	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	8,809	8,809	35
Other Current Liabilities(specify):				
36	<u>Payroll Withholding</u>	13,756	13,756	36
37	<u>Accrued Expenses</u>	37,210	37,210	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 329,140	\$ 329,140	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	918,455	918,455	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)	\$ 918,455	\$ 918,455	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,247,595	\$ 1,247,595	46
47	TOTAL EQUITY(page 18, line 24)	\$ 120,247	\$ 127,158	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,367,842	\$ 1,374,753	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	120,247	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)	\$ 120,247	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)	\$ 120,247	24 *

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Effingham Rehabilitation & Health Care Center # 0047159 Report Period Beginning: 5/1/2005

Ending: 12/31/2005

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 expenses.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 926,298	1
2	Discounts and Allowances for all Level	24,969	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 951,267	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	214,084	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 214,084	8
C. Other Operating Revenue			
9	Payments for Educator		9
10	Other Government Grants		10
11	CNA Training Reimbursement		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	50	13
14	Non-Patient Meals	1,664	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	81,738	17
18	Sale of Supplies to Non-Patient		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	4,695	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 88,147	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income**		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	393	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 393	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,253,891	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	264,838	31
32	Health Care	484,266	32
33	General Administration	223,933	33
B. Capital Expense			
34	Ownership	114,544	34
C. Ancillary Expense			
35	Special Cost Centers	23,278	35
36	Provider Participation Fee	22,785	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,133,644	40
41	Income before Income Taxes (line 30 minus line 40)**	120,247	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 120,247	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. This entity is a cash basis taxpayer.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

**** Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **Effingham Rehabilitation & Health Care Centre**

0047159

Report Period Beginning: **5/1/2005**

Ending:

12/31/2005

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	1,405	1,405	\$ 35,907	\$ 25.56	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,897	3,897	67,837	17.41	3
4	Licensed Practical Nurses	2,758	2,758	39,173	14.20	4
5	CNAs & Orderlies	18,436	18,436	161,766	8.77	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,286	1,286	13,533	10.52	9
10	Activity Assistants	8	8	55	6.88	10
11	Social Service Worker	1,214	1,214	13,735	11.31	11
12	Dietician					12
13	Food Service Supervisor	1,341	1,341	14,783	11.02	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,080	7,080	49,748	7.03	15
16	Dishwashers					16
17	Maintenance Worker	2,521	2,521	18,275	7.25	17
18	Housekeepers	5,328	5,328	43,805	8.22	18
19	Laundry	1,466	1,466	14,379	9.81	19
20	Administrator	1,451	1,451	34,817	24.00	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,050	1,050	14,723	14.02	23
24	Clerical					24
25	Vocational Instructor					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					31
32	Other Health C: Care Plan Coordin	487	487	8,162	16.76	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	49,728	49,728	\$ 530,698 *	\$ 10.67	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	9 visits	4,950	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 4,950		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

SEE ACCOUNTANTS' COMPILATION REPORT

Effingham Rehabilitation & Health Care Center

Provider #: 0047159

5/1/2005 to 12/31/2005

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3) 1,867

Allocated from Home Office

Legal

49

Other

3,433

3,482

Total (agree to Schedule V, line 19, column 8) 5,349

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	8 Amount of Expense Amortized Per Year								
					5 FY2002	6 FY2003	7 FY2004	9 FY2005	10 FY2006	11 FY2007	12 FY2008	13 FY2009	13 FY2010
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6		N/A											
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Effingham Rehabilitation & Health Care Center# 0047159Report Period Beginning: 5/1/2005Ending: 12/31/2005**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? No
If YES, give association name and amount: N/A
- (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? N/A
- (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
- (6) Indicate the total amount of both disposable and non-disposable diaper expenses and the location of this expense on Sch. V. 1,311 Line 10,C2
- (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? No
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

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 22,785
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 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 if 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. \$ 866 Has any meal income been offset against related costs? Yes Indicate the amount \$ 2,011
- (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 program during this reporting period. \$ N/A
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? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, 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

SEE ACCOUNTANTS' COMPILATION REPORT

RECONCILIATION REPORT

10:33 AM 5/16/2006

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	4,537	equal to	4,537	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	51,483	equal to	51,483	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	29,171	equal to	29,171	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	0	equal to	0	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	31,001	equal to	31,001	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	207	equal to	207	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	13,628	equal to	13,628	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages	0	equal to	0	0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	102,313	equal to	102,313	0	O.K.	Pg16 Z12+Z14.	N/A/B	1-4;40-43	8:2	Pg3 H20	N/A	10a	4
Special Serv.- Supplies	272	equal to	272	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39.10a	2
Income Stat. General Serv.	264,838	equal to	264,838	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	484,266	equal to	484,266	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Administration	223,933	equal to	223,933	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	114,544	equal to	114,544	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	23,278	equal to	23,278	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+i	N/A	38to41+43	4
Income Stat. Prov. Partic.	22,785	equal to	22,785	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	312,845	equal to	312,845	0	O.K.	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to	0	0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	13,588	equal to	13,588	0	O.K.	Pg20 K19+K20	A.	9-10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	13,735	equal to	13,735	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	64,531	equal to	64,531	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	18,275	equal to	18,275	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	43,805	equal to	43,805	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	14,379	equal to	14,379	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	34,817	equal to	34,817	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	14,723	equal to	14,723	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to	0	0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	530,698	equal to	530,698	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	0	< or = to	0	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	4,950	< or = to	4,950	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	0	< or = to	0	0	O.K.	Pg20 X14..X16+	B. & C.	17to39 and 50to6	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to	733	-733	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	0	< or = to	0	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	34,817	equal to	34,817	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	20,000	equal to	20,000	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	1,867	equal to	1,867	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	115,890	equal to	115,890	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	6,268	equal to	6,268	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	433	equal to	433	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	22,785	equal to	22,785	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	866	< or = to	2,272	-1,406	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	866	equal to	866	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to	0	0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	1,303	equal to	1,303	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	26,161	equal to	26,161	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6l Y4	B.	14	8
Total loan balance	918,455	equal to	918,455	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27.	N/A	29+39-41	2
Real estate tax accrual	37,300	equal to	37,300	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	50,000	equal to	50,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	729,466	equal to	729,466	0	O.K.	Pg12 to 12l L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	209,074	equal to	209,074	0	O.K.	Pg13 O22+L13	C. & D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	29,576	equal to	29,576	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	120,247	equal to	120,247	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	120,247	equal to	120,247	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to	0	0	O.K.	Pg22 F31-J31..1	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	1,367,842	equal to	1,367,842	0	O.K.	Pg17 H41		25	1	Pg17 S41	N/A	48	1

Effingham Rehabilitation & Health Care Center
IDHFS Comparative Data - Per Resident Day Cost
Year Ending 12/31/2005

Enter your HSA # in next column ===== **4**
 Census (Pulls from Page 2) **10,482**

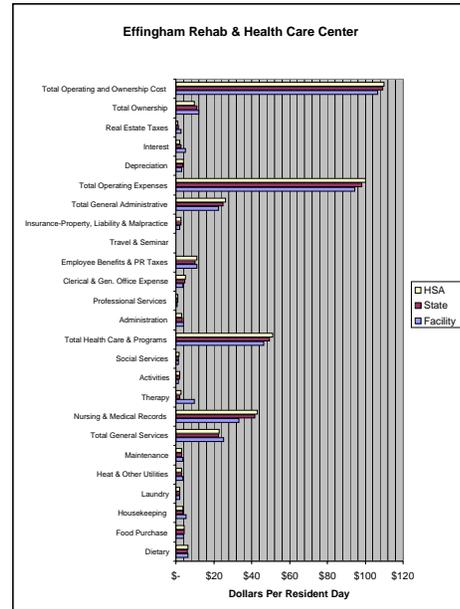
Cost Report Line	Description	Average Median Cost Per Day (2003)		
		Your Facility	State	HSA
1	Dietary	6.55	6.01	6.48
2	Food Purchase	3.92	4.31	4.40
3	Housekeeping	5.25	3.70	3.68
4	Laundry	2.07	1.85	1.90
5	Heat & Other Utilities	3.75	2.95	2.93
6	Maintenance	3.76	3.01	3.03
8	Total General Services	25.33	22.58	22.99
10	Nursing & Medical Records	33.42	41.83	43.12
10A	Therapy	9.76	2.10	2.69
11	Activities	1.42	1.91	1.92
12	Social Services	1.32	1.42	1.64
16	Total Health Care & Programs	46.43	49.48	51.22
17	Administration	4.17	3.36	3.15
19	Professional Services	0.51	0.99	0.85
21	Clerical & Gen. Office Expense	3.73	4.79	4.97
22	Employee Benefits & PR Taxes	11.06	10.09	11.01
24	Travel & Seminar	0.04	0.08	0.13
26	Insurance-Property, Liability & Malpractice	2.02	2.58	2.55
28	Total General Administrative	22.66	24.94	26.11
29	Total Operating Expenses	94.42	98.06	100.03
30	Depreciation	2.96	3.70	4.08
32	Interest	4.91	2.54	1.96
33	Real Estate Taxes	2.78	1.38	1.08
37	Total Ownership and Ownership Cost	106.39	109.17	109.83

Notes:
 Your Facility data is from page 3, column 8 of your 2005 Medicaid cost report, divided by your annual census.
 The Average Median Cost Per Day for the State and your HSA is taken from 2003 data available from the Illinois Department of Healthcare and Family Services and corresponds with the respective cost report data after final adjustments.

IDHFS LTC Profiles

LTC Median Per Diem Cost by HSA - 2003 Cost Reports
2003 (Run June 1, 2004)

Cost Report Line	Description	State-Wide	UN-INFLATED											10th %	90th %
			HSA 1	HSA 2	HSA 3	HSA 4	HSA 5	HSA 6	HSA 7	HSA 8	HSA 9	HSA 10	HSA 11		
1	Dietary	6.01	7.02	6.48	5.50	6.48	5.48	6.06	6.06	6.06	5.60	7.02	5.70	4.13	9.81
2	Food Purchase	4.31	4.47	4.40	4.27	4.40	3.99	4.31	4.31	4.31	4.28	4.47	4.11	3.36	6.04
3	Housekeeping	3.70	3.59	3.68	2.91	3.68	3.40	4.05	4.05	4.05	3.97	3.59	3.61	2.48	5.80
4	Laundry	1.85	2.23	1.90	1.79	1.90	2.10	1.59	1.59	1.59	1.69	2.23	2.13	0.91	3.14
5	Heat & Other Utilities	2.95	3.17	2.93	2.94	2.93	2.71	2.93	2.93	2.93	2.91	3.17	2.95	2.05	4.25
6	Maintenance	3.01	3.26	3.03	2.99	3.03	2.55	3.21	3.21	3.21	3.05	3.26	2.82	1.92	5.12
8	TOTAL GENERAL SERVICES	22.58	24.49	22.99	21.14	22.99	21.47	22.65	22.65	22.65	22.45	24.49	21.73	17.57	31.51
10	Nursing & Medical Records	41.83	42.52	43.12	38.37	43.12	33.78	45.12	45.12	45.12	47.22	42.52	42.15	27.25	64.47
10A	Therapy	2.10	1.86	2.69	3.34	2.69	3.47	1.45	1.45	1.45	2.41	1.86	2.24	-	10.55
11	Activities	1.91	2.18	1.92	1.61	1.92	1.48	2.16	2.16	2.16	2.05	2.18	1.54	1.06	3.45
12	Social Services	1.42	1.45	1.64	1.05	1.64	1.09	1.60	1.60	1.60	1.12	1.45	1.27	0.58	3.00
16	TOTAL HEALTH CARE & PROGRAMS	49.48	50.39	51.22	46.39	51.22	41.58	52.34	52.34	52.34	54.96	50.39	49.49	32.10	77.23
17	Administration	3.36	3.33	3.15	3.15	3.15	3.60	3.46	3.46	3.46	3.04	3.33	3.17	1.71	7.21
19	Professional Services	0.99	1.09	0.85	0.83	0.85	0.76	1.12	1.12	1.12	1.13	1.09	0.77	0.07	3.44
21	Clerical & Gen. Office Expense	4.79	4.32	4.97	3.98	4.97	3.46	5.56	5.56	5.56	5.04	4.32	4.25	2.49	10.78
22	Employee Benefits & PR Taxes	10.09	10.42	11.01	8.88	11.01	7.67	10.51	10.51	10.51	11.38	10.42	9.08	6.33	19.34
24	Travel & Seminar	0.08	0.10	0.13	0.10	0.13	0.13	0.06	0.06	0.06	0.05	0.10	0.07	-	0.43
26	Insurance-Property, liability & Malpractice	2.58	2.47	2.55	2.35	2.55	2.22	2.85	2.85	2.85	2.19	2.47	2.61	0.88	4.32
28	TOTAL GENERAL ADMINISTRATIVE	24.94	25.31	26.11	23.02	26.11	21.37	25.81	25.81	25.81	26.59	25.31	22.93	16.95	39.14
29	TOTAL OPERATING EXPENSES	98.06	100.77	100.03	92.47	100.03	88.05	100.96	100.96	100.96	103.01	100.77	94.71	69.40	142.56
30	Depreciation	3.70	3.82	4.08	3.29	4.08	2.54	4.11	4.11	4.11	3.54	3.82	3.38	1.01	8.43
32	Interest	2.54	2.81	1.96	2.09	1.96	1.41	4.05	4.05	4.05	2.63	2.81	1.50	-	11.53
33	Real Estate Taxes	1.38	0.92	1.08	0.82	1.08	0.80	3.20	3.20	3.20	1.36	0.92	1.11	-	4.85
37	TOTAL OWNERSHIP	111.11													
	TOTAL OPERATING & OWNERSHIP CC	109.17	110.50	109.83	100.47	109.83	95.09	115.50	115.50	115.50	114.03	110.50	103.10	73.16	166.14



	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Adjusted Total
1. Dietary	64,531	2,833	0	67,364	0	67,364	1,260	68,624
2. Food Purchase	0	43,916	0	43,916	0	43,916	-2,837	41,079
3. Housekeeping	43,805	11,204	0	55,009	0	55,009	28	55,037
4. Laundry	14,379	7,361	0	21,740	0	21,740	2	21,742
5. Heat and Other Utilities	0	0	39,061	39,061	0	39,061	208	39,269
6. Maintenance	18,275	17,991	1,482	37,748	0	37,748	1,654	39,402
7. Other (specify)*	0	0	0	0	0	0	360	360
8. Total General Services	140,990	83,305	40,543	264,838	0	264,838	675	265,513
9. Medical Director	0	0	4,950	4,950	0	4,950	0	4,950
10. Nursing & Medical Records	312,845	35,380	0	348,225	0	348,225	2,086	350,311
10a. Therapy	0	51	102,262	102,313	0	102,313	1	102,314
11. Activities	13,588	602	733	14,923	0	14,923	0	14,923
12. Social Services	13,735	120	0	13,855	0	13,855	0	13,855
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	289	289
16. Total Health Care & Programs	340,168	36,153	107,945	484,266	0	484,266	2,376	486,642
17. Administrative	34,817	0	20,000	54,817	0	54,817	-11,070	43,747
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	1,867	1,867	0	1,867	3,482	5,349
20. Fees, Subscriptions & Promotion	0	0	3,928	3,928	0	3,928	2,340	6,268
21. Clerical & General Office	14,723	4,074	8,201	26,998	0	26,998	12,120	39,118
22. Employee Benefits & Payroll	0	0	113,618	113,618	0	113,618	2,272	115,890
23. Inservice Training & Education	0	0	0	0	0	0	187	187
24. Travel and Seminar	0	0	176	176	0	176	257	433
25. Other Admin. Staff Trans	0	0	1,738	1,738	0	1,738	1,105	2,843
26. Insurance-Prop.Liab.Malpractice	0	0	20,791	20,791	0	20,791	341	21,132
27. Other (specify)*	0	0	0	0	0	0	2,563	2,563
28. Total General Adminis	49,540	4,074	170,319	223,933	0	223,933	13,597	237,530
29. Total General Administrative	530,698	123,532	318,807	973,037	0	973,037	16,648	989,685
30. Depreciation	0	0	25,420	25,420	0	25,420	5,581	31,001
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	46,376	46,376	0	46,376	5,107	51,483
33. Real Estate	0	0	29,171	29,171	0	29,171	0	29,171
34. Rent - Facility & Grounds	0	0	0	0	0	0	207	207
35. Rent - Equipment & Vehicles	0	0	13,577	13,577	0	13,577	51	13,628
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	114,544	114,544	0	114,544	10,946	125,490
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	221	0	221	0	221	0	221
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	22,785	22,785	0	22,785	0	22,785
43. Other (specify):*	0	0	23,057	23,057	0	23,057	-23,057	0
44. Total Special Cost Ce	0	221	45,842	46,063	0	46,063	-23,057	23,006
45. Grand Total	530,698	123,753	479,193	1,133,644	0	1,133,644	4,537	1,138,181

	After	
	Operating	Consolidation
General Service Cost Center		
1. Cash on hand and in banks	500	500
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	407,246	407,246
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	1,394	1,394
7. Other Prepaid Expenses	4,262	4,262
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	0	0
10. Total current assets	413,402	413,402
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	50,000	50,000
14. Buildings, at Historical Cost	718,400	728,845
15. Leasehold Improvements, Historical Cost	0	621
16. Equipment, at Historical Cost	209,074	209,074
17. Accumulated Depreciation (book methods)	-25,421	-29,576
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	2,387	2,387
24. Total Long-Term Assets	954,440	961,351
25. Total Assets	1,367,842	1,374,753
CURRENT LIABILITIES		
26. Accounts Payable	203,001	203,001
27. Officer's Accounts Payable	107	107
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	26,372	26,372
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	37,300	37,300
33. Accrued Interest Payable	2,585	2,585
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	8,809	8,809
36. Other Current Liabilities (specify):	13,756	13,756
37. Other Current Liabilities (specify):	37,210	37,210
38. Total Current Liabilities	329,140	329,140
LONG TERM LIABILITES		
39. Long-Term Notes Payable	0	0
40. Mortgage Payable	918,455	918,455
41. Bonds Payable	0	0
42. Deferred Compensation	0	0
43. Other Long-Term Liabilities (specify):	0	0
44. Other Long-Term Liabilities (specify):	0	0
45. Total Long-Term Liabilities	918,455	918,455
46. Total Liabilities	1,247,595	1,247,595
47. Total Equity	120,247	127,158
48. Total Liabilities and Equity	1,367,842	1,374,753

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	926,298
2. Discounts and Allowances for all Levels	24,969
Subtotal - Inpatient Care	951,267
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	214,084
7. Oxygen	0
Subtotal - Ancillary Revenue	214,084
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	50
14. Non-Patient Meals	1,664
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	81,738
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiology and X-Ray	0
21. Other Medical Services	4,695
22. Laundry	0
Subtotal - Other Operating Revenue	88,147
24. Contributions	0
25. Interest and Other Investments Income	0
Subtotal - Non-Operating Revenue	-
27. Other Revenue (specify):	393
28. Other Revenue (specify):	0
Subtotal - Other Revenue	393
30. Total Revenue	1,253,891
31. General Services	264,838
32. Health Care	484,266
33. General Administration	223,933
34. Ownership	114,544
35. Special Cost Centers	23,278
35. Provider Participation Fee	22,785
37. Other	0
40. Total Expenses	1,133,644
41. Income Before Income Taxes	120,247
42. Income Taxes	0
43. Net Income or Loss for the Year	120,247