

		FOR BHF USE					

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**2006**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2006)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

**I. IDPH Facility ID Number:** 0046045

**Facility Name:** Arcola Health Care Center

**Address:** 422 East Fourth South Street Arcola 61910  
 Number City Zip Code

**County:** Douglas

**Telephone Number:** (217) 268-3022 **Fax #** (217) 268-4180

**HFS ID Number:** 371316056001

**Date of Initial License for Current Owners:** 11/09/93

**Type of Ownership:**

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input checked="" type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

**In the event there are further questions about this report, please contact:**  
**Name:** Christine A. Hanover **Telephone Number:** (312) 634-4581  
 Please send copies of desk review and audit adjustments to address on this page.

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/06 to 12/31/06 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

<b>Officer or Administrator of Provider</b>	(Signed) _____
	(Date) _____
<b>Paid Preparer</b>	(Type or Print Name) _____
	(Title) _____
<b>Paid Preparer</b>	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u>
	(Date) _____
<b>Paid Preparer</b>	(Print Name and Title) _____
	(Firm Name & Address) <u>McGladrey &amp; Pullen, LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u>
<b>Paid Preparer</b>	(Telephone) <u>(312) 384-6000</u> Fax # <u>(312) 634-5518</u>
	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arcola Health Care Center

# 0046045 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	50	Skilled (SNF)	50	18,250	1
2		Skilled Pediatric (SNF/PED)			2
3	50	Intermediate (ICF)	50	18,250	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	100	TOTALS	100	36,500	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	
		Medicaid Recipient	Private Pay	Other		
8	SNF		3,275	868	4,143	8
9	SNF/PED					9
10	ICF	28,389		1,273	29,662	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,389	3,275	2,141	33,805	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.62%

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 11/09/1993

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

YES  Date 11/09/1993 NO

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

YES  NO  If YES, enter number of beds certified 17 and days of care provided 868

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: 12/31/2006 Fiscal Year: 12/31/2006

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arcola Health Care Center # 0046045 Report Period Beginning: 01/01/06 Ending: 12/31/06

**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
	<b>A. General Services</b>										
1	Dietary	130,131	14,438	1,680	146,249		146,249	2,404	148,653		1
2	Food Purchase		141,906		141,906		141,906	(6,613)	135,293		2
3	Housekeeping	85,367	20,130		105,497		105,497	106	105,603		3
4	Laundry	43,319	8,932		52,251		52,251		52,251		4
5	Heat and Other Utilities			93,287	93,287		93,287	446	93,733		5
6	Maintenance	32,599	18,979	2,577	54,155		54,155	6,113	60,268		6
7	Other (specify):* <b>Home Office Benefits</b>							963	963		7
8	<b>TOTAL General Services</b>	291,416	204,385	97,544	593,345		593,345	3,419	596,764		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			33,860	33,860		33,860		33,860		9
10	Nursing and Medical Records	802,331	41,648	11,117	855,096		855,096	8,079	863,175		10
10a	Therapy			54,628	54,628		54,628	798	55,426		10a
11	Activities	60,258	3,940	571	64,769		64,769		64,769		11
12	Social Services	23,218			23,218		23,218		23,218		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <b>Home Office Benefits</b>							2,687	2,687		15
16	<b>TOTAL Health Care and Programs</b>	885,807	45,588	100,176	1,031,571		1,031,571	11,564	1,043,135		16
	<b>C. General Administration</b>										
17	Administrative	41,192			41,192		41,192	23,692	64,884		17
18	Directors Fees										18
19	Professional Services			11,589	11,589		11,589	9,625	21,214		19
20	Dues, Fees, Subscriptions & Promotions			4,019	4,019		4,019	1,017	5,036		20
21	Clerical & General Office Expenses	18,776	4,724	9,426	32,926		32,926	37,715	70,641		21
22	Employee Benefits & Payroll Taxes			238,829	238,829		238,829	3,493	242,322		22
23	Inservice Training & Education			350	350		350	309	659		23
24	Travel and Seminar			230	230		230	350	580		24
25	Other Admin. Staff Transportation			7,955	7,955		7,955	2,460	10,415		25
26	Insurance-Prop.Liab.Malpractice			27,234	27,234		27,234	1,820	29,054		26
27	Other (specify):* <b>Home Office Benefits</b>							6,750	6,750		27
28	<b>TOTAL General Administration</b>	59,968	4,724	299,632	364,324		364,324	87,231	451,555		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,237,191	254,697	497,352	1,989,240		1,989,240	102,214	2,091,454		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.

\*\*See schedule of adjustments attached at end of cost report.

Facility Name &amp; ID Number

Arcola Health Care Center

#0046045

Report Period Beginning:

01/01/06

Ending:

12/31/06

## 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	
	<b>D. Ownership</b>											
30	Depreciation			50,594	50,594		50,594	14,125	64,719			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			231,498	231,498		231,498	1,067	232,565			32
33	Real Estate Taxes			33,060	33,060		33,060	(2,015)	31,045			33
34	Rent-Facility & Grounds							1,070	1,070			34
35	Rent-Equipment & Vehicles			6,085	6,085		6,085	561	6,646			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			321,237	321,237		321,237	14,808	336,045			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		8,405	45	8,450		8,450		8,450			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,750	54,750		54,750		54,750			42
43	Other (specify):* <b>Nonallowable Cost</b>			46,494	46,494		46,494	(46,494)				43
44	<b>TOTAL Special Cost Centers</b>		8,405	101,289	109,694		109,694	(46,494)	63,200			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,237,191	263,102	919,878	2,420,171		2,420,171	70,528	2,490,699			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

See Accountant's Compilation Report

Facility Name & ID Number Arcola Health Care Center

# 0046045

Report Period Beginning: 01/01/06

Ending: 12/31/06

**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 Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(5,331)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	4,708	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(943)	43		13
14	Non-Care Related Interest	(2,124)	32		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	(690)	43		18
19	Entertainment				19
20	Contributions	(18)	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	(7,388)	43		24
25	Fund Raising, Advertising and Promotional	(3,169)	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	(48,089)	Varies		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (63,044)		\$	30

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)	133,572	Varies	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 133,572		36
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 70,528		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 Shops		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' COMPILATION REPORT

Arcola Health Care Center

ID# 0046045

Report Period Beginning: 01/01/06

Ending: 12/31/06

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	Sch. V Line
1	Nonallowable marketing events	\$ (2,709)	43	1
2	Labs - Part A	(12,255)	43	2
3	X-Rays - Part A	(1,551)	43	3
4	Offset Vending Machine Exp	(12,440)	43	4
5	Non-care real estate taxes	(3,119)	33	5
6	Offset meal revenue	(3,193)	2	6
7	Non-care interest expense	(2,040)	32	7
8	Misc Income - Nursing Sup	(612)	10	8
9	Misc Income - Office Sup	(20)	21	9
10	Misc Income - Food	(45)	2	10
11	Misc Income - Other	(457)	21	11
12	Non-Allowable HO - Arcitect Fees	(750)	19	12
13	Non-Allowable HO - Travel Exp	(8,898)	24	13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(48,089)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Arcola Health Care Center

# 0046045

Report Period Beginning:

01/01/06

Ending:

12/31/06

**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	<b>Operating Expenses</b>	<b>PAGES</b>	<b>PAGE</b>	<b>PAGE</b>	<b>PAGE</b>	<b>PAGE</b>	<b>PAGE</b>	<b>PAGE</b>	<b>PAGE</b>	<b>PAGE</b>	<b>PAGE</b>	<b>PAGE</b>	<b>SUMMARY</b>	
	<b>A. General Services</b>	<b>5 &amp; 5A</b>	<b>6</b>	<b>6A</b>	<b>6B</b>	<b>6C</b>	<b>6D</b>	<b>6E</b>	<b>6F</b>	<b>6G</b>	<b>6H</b>	<b>6I</b>	<b>TOTALS</b>	
													<b>(to Sch V, col.7)</b>	
1	Dietary	0	2,404	0	0	0	0	0	0	0	0	0	2,404	1
2	Food Purchase	(3,238)	118	0	0	0	0	0	0	0	0	0	(3,120)	2
3	Housekeeping	0	106	0	0	0	0	0	0	0	0	0	106	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	446	0	0	0	0	0	0	0	0	0	446	5
6	Maintenance	0	6,113	0	0	0	0	0	0	0	0	0	6,113	6
7	Other (specify):*	0	963	0	0	0	0	0	0	0	0	0	963	7
8	<b>TOTAL General Services</b>	<b>(3,238)</b>	<b>10,150</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>6,912</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(612)	8,691	0	0	0	0	0	0	0	0	0	8,079	10
10a	Therapy	0	798	0	0	0	0	0	0	0	0	0	798	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	2,687	0	0	0	0	0	0	0	0	0	2,687	15
16	<b>TOTAL Health Care and Programs</b>	<b>(612)</b>	<b>12,176</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>11,564</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	23,692	0	0	0	0	0	0	0	0	0	23,692	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(750)	10,375	0	0	0	0	0	0	0	0	0	9,625	19
20	Fees, Subscriptions & Promotions	0	1,017	0	0	0	0	0	0	0	0	0	1,017	20
21	Clerical & General Office Expenses	(477)	0	38,192	0	0	0	0	0	0	0	0	37,715	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	309	0	0	0	0	0	0	0	0	309	23
24	Travel and Seminar	(8,898)	0	9,248	0	0	0	0	0	0	0	0	350	24
25	Other Admin. Staff Transportation	0	0	2,460	0	0	0	0	0	0	0	0	2,460	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,820	0	0	0	0	0	0	0	0	1,820	26
27	Other (specify):*	0	0	6,750	0	0	0	0	0	0	0	0	6,750	27
28	<b>TOTAL General Administration</b>	<b>(10,125)</b>	<b>35,084</b>	<b>58,779</b>	<b>0</b>	<b>83,738</b>	<b>28</b>							
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(13,975)</b>	<b>57,410</b>	<b>58,779</b>	<b>0</b>	<b>102,214</b>	<b>29</b>							



**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	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	\$	Petersen Health Care, Inc.	100.00%	\$ 2,404	\$ 2,404	1	
2	V	2 Food		Petersen Health Care, Inc.	100.00%	118	118	2	
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	106	106	3	
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	0		4	
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	446	446	5	
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	6,113	6,113	6	
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	963	963	7	
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	8,691	8,691	8	
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	798	798	9	
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	2,687	2,687	10	
11	V	17 Administrative		Petersen Health Care, Inc.	100.00%	23,692	23,692	11	
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	10,375	10,375	12	
13	V	20 Due, Fees, Subs & Promos		Petersen Health Care, Inc.	100.00%	1,017	1,017	13	
14	Total		\$			\$ 57,410	\$ *	57,410	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	21 Clerical & General Office	\$	Petersen Health Care, Inc.	100.00%	\$ 38,192	\$	38,192	15
16	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	309		309	16
17	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	9,248		9,248	17
18	V	25 Other Admin. Staff Transport		Petersen Health Care, Inc.	100.00%	2,460		2,460	18
19	V	26 Insurance-Prop.Liab.Malpractice		Petersen Health Care, Inc.	100.00%	1,820		1,820	19
20	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	6,750		6,750	20
21	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	9,417		9,417	21
22	V	32 Interest		Petersen Health Care, Inc.	100.00%	5,231		5,231	22
23	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	1,104		1,104	23
24	V	34 Rent - Facility & Grounds		Petersen Health Care, Inc.	100.00%	1,070		1,070	24
25	V	35 Rent - Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	561		561	25
26	V								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		\$			\$ 76,162	\$ *	76,162	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number     Arcola Health Care Center    

#     0046045    

Report Period Beginning:     01/01/06    

Ending:     12/31/06    

**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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	0 \$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arcola Health Care Center # 0046045 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	See Schedule 7A	1.48	2.96	Salary	\$ 23,692	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	\$ 23,692		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 Arcola Health Care Center

# 0046045

Report Period Beginning:

01/01/06

Ending: 12/31/06

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	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	Patient Days	1,141,463	56	\$ 81,179	\$ 33,805	\$ 2,404	1
2	2	Food	Patient Days	1,141,463	56	3,989	33,805	118	2
3	3	Housekeeping	Patient Days	1,141,463	56	3,589	33,805	106	3
4	4	Laundry	Patient Days	1,141,463	56	0	33,805	0	4
5	5	Utilities	Patient Days	1,141,463	56	15,054	33,805	446	5
6	6	Maintenance	Patient Days	1,141,463	56	206,416	110,513	6,113	6
7	7	Mgmt. Allocation of Benefits	Patient Days	1,141,463	56	32,526	33,805	963	7
8	10	Nursing and Medical Records	Patient Days	1,141,463	56	293,462	289,197	8,691	8
9	10A	Therapy	Patient Days	1,141,463	56	26,945	33,805	798	9
10	15	Mgmt. Allocation of Benefits	Patient Days	1,141,463	56	90,724	33,805	2,687	10
11	17	Administrative	Patient Days	1,141,463	56	800,000	800,000	23,692	11
12	19	Professional Services	Patient Days	1,141,463	56	350,361	33,805	10,375	12
13	20	Due, Fees, Subs & Promos	Patient Days	1,141,463	56	34,325	33,805	1,017	13
14	21	Clerical & General Office	Patient Days	1,141,463	56	1,289,623	954,322	38,192	14
15	23	Inservice Training & Education	Patient Days	1,141,463	56	10,426	33,805	309	15
16	24	Travel and Seminar	Patient Days	1,141,463	56	312,259	33,805	9,248	16
17	25	Other Admin. Staff Transport	Patient Days	1,141,463	56	83,062	33,805	2,460	17
18	26	Insurance-Prop.Liab.Malpractice	Patient Days	1,141,463	56	61,457	33,805	1,820	18
19	27	Mgmt Allocation of Benefits	Patient Days	1,141,463	56	227,912	33,805	6,750	19
20	30	Depreciation	Patient Days	1,141,463	56	317,964	33,805	9,417	20
21	32	Interest	Patient Days	1,141,463	56	176,614	33,805	5,231	21
22	33	Real Estate Taxes	Patient Days	1,141,463	56	37,282	33,805	1,104	22
23	34	Rent - Facility & Grounds	Patient Days	1,141,463	56	36,133	33,805	1,070	23
24	35	Rent - Equipment & Vehicles	Patient Days	1,141,463	56	18,933	33,805	561	24
25	TOTALS					\$ 4,510,235	\$ 2,234,999	\$ 133,572	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arcola Health Care Center # 0046045 Report Period Beginning: 01/01/06 Ending: 12/31/06

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	2	3	4	5	6	7	8	9	10										
										Name of Lender		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																			
<b>Long-Term</b>																			
1	LaSalle Bank	X	Mortgage	3244 plus int.	08/31/02	\$ 2,995,391	\$ 2,806,919	08/31/07	Varies	\$ 213,176	1								
2	Ford Credit	X	Van Purchase	\$639.08	11/22/04	33,217	19,967	11/17/09	0.0590	1,381	2								
3						Interest Income Offset				(2,124)	3								
4						Non-Allowable Interest				(2,040)	4								
5						Allocated from Home Office				5,231	5								
<b>Working Capital</b>																			
6	LaSalle Bank	X	Line of Credit	Varies	08/31/02	259,880		08/31/06	0.0975	14,901	6								
7											7								
8											8								
9	<b>TOTAL Facility Related</b>			\$639.08		\$ 3,288,488	\$ 2,826,886			\$ 230,525	9								
<b>B. Non-Facility Related*</b>																			
10	First National Bank of Arcola	X	Mortgage on House	\$485.00	05/15/96	62,800		07/07/06	0.0800	2,040	10								
11											11								
12											12								
13											13								
14	<b>TOTAL Non-Facility Related</b>			\$485.00		\$ 62,800	\$			\$ 2,040	14								
15	<b>TOTALS (line 9+line14)</b>					\$ 3,351,288	\$ 2,826,886			\$ 232,565	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><b>Important</b>, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																																				
1. Real Estate Tax accrual used on 2005 report.		\$	<b>20,350</b> 1																																	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2006	\$	<b>28,410</b> 2																																	
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>8,060</b> 3																																	
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>25,000</b> 4																																	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	5																																	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.	<p><b>Rental House Taxes - Non-Allowable</b> <b>Home Office Allocation</b></p>		<b>(3,119)</b> <b>1,104</b>																																	
<b>TOTAL REFUND \$</b> _____ <b>For</b> _____ <b>Tax Year.</b> <b>(Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6																																	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>31,045</b> 7																																	
Real Estate Tax History:																																				
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2001</td><td><u>22,337</u></td><td>8</td></tr> <tr><td>2002</td><td><u>22,534</u></td><td>9</td></tr> <tr><td>2003</td><td><u>24,341</u></td><td>10</td></tr> <tr><td>2004</td><td><u>27,991</u></td><td>11</td></tr> <tr><td>2005</td><td><u>28,410</u></td><td>12</td></tr> </table>	2001	<u>22,337</u>	8	2002	<u>22,534</u>	9	2003	<u>24,341</u>	10	2004	<u>27,991</u>	11	2005	<u>28,410</u>	12	<table border="1"> <tr><td colspan="2"><b>FOR BHF USE ONLY</b></td><td></td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2005</td><td>\$</td><td>13</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5</td><td>\$</td><td>14</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6</td><td>\$</td><td>15</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION</td><td>\$</td><td>16</td></tr> </table>	<b>FOR BHF USE ONLY</b>			13	FROM R. E. TAX STATEMENT FOR 2005	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
2001	<u>22,337</u>	8																																		
2002	<u>22,534</u>	9																																		
2003	<u>24,341</u>	10																																		
2004	<u>27,991</u>	11																																		
2005	<u>28,410</u>	12																																		
<b>FOR BHF USE ONLY</b>																																				
13	FROM R. E. TAX STATEMENT FOR 2005	\$	13																																	
14	PLUS APPEAL COST FROM LINE 5	\$	14																																	
15	LESS REFUND FROM LINE 6	\$	15																																	
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																																	
<b>Accrual based on prior year tax bill.</b>																																				

**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.**

SEE ACCOUNTANTS' COMPILATION REPORT

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 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 2006 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.

**2005 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Arcola Health Care Center COUNTY Douglas

FACILITY IDPH LICENSE NUMBER 0046045

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 2005 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 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>01-14-09-200-00580</u>	<u>Nursing Home</u>	\$ <u>24,968.36</u>	\$ <u>24,968.36</u>
2. <u>01-14-09-200-005</u>	<u>Nursing Home</u>	\$ <u>322.50</u>	\$ <u>322.50</u>
3. <u>01-14-09-224-003</u>	<u>Home used by Administrator</u>	\$ <u>3,119.28</u>	\$ _____
4. _____	<u>Home Office Allocation</u>	\$ _____	\$ <u>1,104.00</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>28,410.14</u>	\$ <u>26,394.86</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? X YES \_\_\_\_\_ 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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

Facility Name & ID Number Arcola Health Care Center# 0046045

Report Period Beginning:

01/01/06

Ending:

12/31/06**X. BUILDING AND GENERAL INFORMATION:**A. Square Feet: 22,000 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1C. 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).

NoneF. 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>Resident Use</u>	<u>Not Available</u>	<u>1993</u>	<u>\$ 44,078</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>			<b>\$ 44,078</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Arcola Health Care Center

# 0046045

Report Period Beginning:

01/01/06

Ending:

12/31/06

**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	100		1995	1975	\$ 859,153	\$	35	\$ 24,547	\$ 24,547	\$ 282,290	4
5											5
6	Allocated from Home Office			2006	20,161			882	882	882	6
7											7
8											8
	<b>Improvement Type**</b>										
9	Building Improvement			1993	13,499		20	675	675	9,112	9
10	Building Improvement			1994	31,000		20	1,550	1,550	19,325	10
11	Building Improvement			1995	10,602		20	530	530	6,340	11
12	Landscaping			1997	5,593		20	280	280	2,659	12
13	Parking Lot			1997	6,500		20	325	325	3,088	13
14	Carpeting			1997	934		20	47	47	445	14
15	Door Closer			1997	1,225		20	61	61	581	15
16	Driveway Grading			1998	784		15	52	52	443	16
17	Guttering			1998	1,273		15	85	85	722	17
18	Wiring			1998	6,426		20	321	321	2,730	18
19	Windows			1998	2,330		15	155	155	1,319	19
20	Siding			1998	12,606		20	630	630	5,356	20
21	Doors			1998	765		15	51	51	434	21
22	Sink			1998	901		20	45	45	585	22
23	Garage			1998	8,286		15	552	552	4,693	23
24	Wood Flooring			1999	1,174		20	59	59	441	24
25	Asphalt Lot			1999	4,680		20	234	234	1,755	25
26	Tile			1999	6,477		20	324	324	2,428	26
27	Vinyl Siding			1999	5,600		25	224	224	1,680	27
28	Door Alarms			2000	1,593		20	80	80	519	28
29	Water Heater			2000	5,075		20	254	254	1,651	29
30	Sidewalk			2000	876		20	44	44	286	30
31	Carpeting			2000	670		20	34	34	220	31
32	Scarf Swags/Valances			2001	6,043		20	302	302	1,510	32
33	Scarf Holders			2001	1,083		20	54	54	270	33
34	Fence			2001	2,000		20	100	100	500	34
35	Replacement Wall			2001	686		20	34	34	171	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

Facility Name & ID Number Arcola Health Care Center

# 0046045

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Security System	2002	\$ 5,959	\$	20	\$ 298	\$ 298	\$ 1,341	37
38	Sprinkler System	2002	4,946		20	247	247	1,114	38
39	Sign	2002	1,248		20	62	62	668	39
40	Medicare Wing Expansion	2003	100,808		20	5,040	5,040	17,641	40
41	Architect Fees	2003	1,343		20	67	67	268	41
42	Patio	2003	5,858		20	293	293	1,172	42
43	Medicare Wing Expansion	2003	2,500		20	125	125	438	43
44	Medicare Wing Expansion	2003	750		20	38	38	131	44
45	Medicare Wing Expansion	2003	1,500		20	75	75	263	45
46	Medicare Wing Expansion	2003	500		20	25	25	88	46
47	Furnace	2004	2,195		20	110	110	275	47
48	Roofing	2005	2,500		20	125	125	189	48
49	Asphalt West Lot	2006	21,480		20	537	537	537	49
50									50
51	Land Improvement Depreciation per Books			1,274			(1,274)		51
52	Building Depreciation per Books			23,371			(23,371)		52
53	Building Improvement Depreciation per Books			5,120			(5,120)		53
54									54
55									55
56									56
57									57
58	2006 Home Office allocation-Land & Land Improvements	2006	1,165			108	108	108	58
59	2006 Home Office allocation-Building Improvements	2006	33			2	2	2	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)		\$ 1,170,780	\$ 29,765		\$ 39,684	\$ 9,919	\$ 376,666	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Arcola Health Care Center

# 0046045

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	\$ 101,356	\$ 10,171	\$ 9,967	\$ (204)	10	\$ 57,069	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	128,973					128,973	73
74	Allocation from Home Office			8,425	8,425			74
75	TOTALS	\$ 230,329	\$ 10,171	\$ 18,392	\$ 8,221		\$ 186,042	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	1994 Dodge Van	1998	\$ 28,010	\$ 1,775	\$	\$ (1,775)	5	\$ 28,010	76
77	Facility	2005 Ford	2004	33,217	6,378	6,643	265	5	16,609	77
78										78
79										79
80	TOTALS			\$ 61,227	\$ 8,153	\$ 6,643	\$ (1,510)		\$ 44,619	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,506,414	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 48,089	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 64,719	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 16,630	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 607,327	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	Land & House - 1996	\$ 78,850	\$ 2,504	\$ 26,061	86
87	Vending Machine - 1995	3,856		3,856	87
88					88
89					89
90					90
91	TOTALS	\$ 82,706	\$ 2,504	\$ 29,917	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.

SEE ACCOUNTANTS' COMPILATION REPORT

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.  YES  NO

	1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:			\$			3
4	Additions						4
5							5
6	<u>Other (Home Office Allocation)</u>			<u>1,070</u>			6
7	<b>TOTAL</b>			\$ <b>1,070</b>			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: N/A \*

**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: \$ 6,646 Description: Copier 2753, MedaSTAT 3332, Home Ofc. 561

(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			\$ <u>N/A</u>	\$	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	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. \_\_\_\_\_ /2007 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2008 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2009 \$ \_\_\_\_\_

\* 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.

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
  - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- 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	10A, 3	hrs	\$	368	\$ 29,287	\$	368	\$ 29,287	1
2	Licensed Speech and Language Development Therapist	10A, 3	hrs		11	994		11	994	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A, 3	hrs		315	24,347		315	24,347	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				7,748		7,748	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39, 3			1	45		1	45	12
13	Other (specify): <u>Oxygen</u>	39, 2					657		657	13
14	<b>TOTAL</b>			\$	695	\$ 54,673	\$ 8,405	695	\$ 63,078	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.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Arcola Health Care Center # 0046045 Report Period Beginning: 01/01/06 Ending: 12/31/06  
 XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/06 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 353,274	\$ 353,274	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>-0-</u> )	335,374	335,374	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	300	300	6
7	Other Prepaid Expenses	2,734	2,734	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 691,682	\$ 691,682	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		44,078	13
14	Buildings, at Historical Cost	1,220,027	1,170,779	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	310,430	291,557	16
17	Accumulated Depreciation (book methods)	(612,957)	(607,327)	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>Due from MBP</u>	2,608,147	2,660,396	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 3,525,647	\$ 3,559,483	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 4,217,329	\$ 4,251,165	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 299,610	\$ 299,610	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	73,845	73,845	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,828	1,828	31
32	Accrued Real Estate Taxes(Sch.IX-B)	25,000	25,000	32
33	Accrued Interest Payable	15,005	15,005	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Accrued Expense</u>	14,514	14,514	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 429,802	\$ 429,802	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	19,967	19,967	39
40	Mortgage Payable	2,806,919	2,806,919	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 2,826,886	\$ 2,826,886	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 3,256,688	\$ 3,256,688	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 960,641	\$ 994,477	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 4,217,329	\$ 4,251,165	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>653,894</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Post Cost Report Audit Adjustment</b>	<b>(26,378)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>627,516</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>333,120</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe) <b>Rounding</b>	<b>5</b>	<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>333,125</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>960,641</b>	<b>24</b> *

Operating Entity Only

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arcola Health Care Center

# 0046045

Report Period Beginning: 01/01/06

Ending: 12/31/06

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,558,373	1
2	Discounts and Allowances for all Levels	11,738	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,570,111	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	95,047	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 95,047	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants	21,934	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	3,193	14
15	Telephone, Television and Radio	3,916	15
16	Rental of Facility Space		16
17	Sale of Drugs	38,836	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	4,173	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 72,052	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	2,124	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 2,124	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Vending</b>	12,823	28
28a	<b>Miscellaneous (Sch 19A)</b>	1,134	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 13,957	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,753,291	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	593,345	31
32	Health Care	1,031,571	32
33	General Administration	364,324	33
<b>B. Capital Expense</b>			
34	Ownership	321,237	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	54,944	35
36	Provider Participation Fee	54,750	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,420,171	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	333,120	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 333,120	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 tax payer.

\*\*\* 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.

Prairie Rose Health Care Center  
Facility # 0046045  
January 1, 2006 - December 31, 2006

Schedule 19A

XVII. INCOME STATEMENT

Line 28a - Other revenue

Medical Supplies	611
Other	458
Food	45
Office Supplies	<u>20</u>
	<u><u>1,134</u></u>

Facility Name & ID Number Arcola Health Care Center

# 0046045

Report Period Beginning: 01/01/06

Ending:

12/31/06

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	1,907	1,907	\$ 38,686	\$ 20.29	1
2	Assistant Director of Nursing	509	509	10,051	19.75	2
3	Registered Nurses	1,936	2,072	40,254	19.43	3
4	Licensed Practical Nurses	15,559	16,225	264,129	16.28	4
5	CNAs & Orderlies	42,808	44,649	403,675	9.04	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,816	1,980	20,004	10.10	9
10	Activity Assistants	1,911	2,047	18,632	9.10	10
11	Social Service Workers	867	867	23,218	26.79	11
12	Dietician			0		12
13	Food Service Supervisor	2,080	2,080	27,041	13.00	13
14	Head Cook			0		14
15	Cook Helpers/Assistants	12,615	13,113	103,090	7.86	15
16	Dishwashers					16
17	Maintenance Workers	2,652	2,764	32,599	11.79	17
18	Housekeepers	10,768	11,104	85,367	7.69	18
19	Laundry	7,119	7,351	43,319	5.89	19
20	Administrator	2,860	2,860	41,192	14.40	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,793	1,913	18,776	9.82	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					31
32	Other Health Care Plan Coord.	2,080	2,080	45,535	21.89	32
33	Other(specify) <u>Transportation</u>	1,980	2,117	21,622	10.21	33
34	TOTAL (lines 1 - 33)	111,260	115,638	\$ 1,237,191 *	\$ 10.70	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	32	\$ 1,680	1, 3	35
36	Medical Director	Monthly	33,860	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,600	10, 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	32	\$ 37,140		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	17	\$ 705	10, 3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	437	8,812	10, 3	52
53	TOTAL (lines 50 - 52)	454	\$ 9,517		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arcola Health Care Center

# 0046045

Report Period Beginning: 01/01/06

Ending: 12/31/06

**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	
Sheila Hopkins	Administrator	0	\$ 20,567	Workers' Compensation Insurance	\$ 34,720	IDPH License Fee	\$ 687	
Joan Cook	Administrator	0	20,625	Unemployment Compensation Insurance	21,236	Advertising: Employee Recruitment	891	
				FICA Taxes	92,342	Health Care Worker Background Check (Indicate # of checks performed <u>231</u> )	2,314	
				Employee Health Insurance	84,811	<u>Above Background Checks for Patient and employees.</u>		
				Employee Meals	3,493	Miscellaneous Dues & Subscriptions	127	
				Illinois Municipal Retirement Fund (IMRF)*		Allocated from Home Office	1,017	
				Employee Retirement	2,962			
				Employee Relations	2,758	Less: Public Relations Expense	( )	
						Non-allowable advertising	( )	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 41,192	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
B. Administrative - Other								
Description			Amount					
N/A			\$					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$					
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Altschuler, Melvoin & Glasser,	Accounting		\$ 5,850	N/A		\$	Out-of-State Travel	\$
Lindin Engineering	Cost Segregation		2,892					
LTC Solutions, Inc.	Computer Services		2,640				In-State Travel	
Misc Computer Services	Computer Services		207					
							Seminar Expense	230
							Allocated from Home Office	350
							Entertainment Expense	( )
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 11,589	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
1			\$		\$	\$	\$	\$ N/A	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	<b>TOTALS</b>		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Arcola Health Care Center

# 0046045

Report Period Beginning: 01/01/06

Ending: 12/31/06

**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? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (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. \$ 2,021 Line 10, 2
- (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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 54,750  
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. \$ 3,493 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 3,193
- (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. \$ 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? Yes
- 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? Yes  
Firm Name: Ginoli & Co 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 current 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 \$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**