

Facility Name & ID Number Cisne Rehabilitation & Health Care Center

0047423 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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	35	Intermediate (ICF)	35	12,775	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	35	TOTALS	35	12,775	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF	6,128	1,597		7,725
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	6,128	1,597		7,725

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 60.47%

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 10/1/2005

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

YES Date 10/1/2005 NO

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

YES NO If YES, enter number of beds certified 0 and days of care provided N/A

Medicare Intermediary N/A

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.

Facility Name & ID Number Cisne Rehabilitation & Health Care Center # 0047423 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
	A. General Services										
1	Dietary	57,480	3,533	5,627	66,640		66,640	767	67,407		1
2	Food Purchase		35,142		35,142		35,142	(3,836)	31,306		2
3	Housekeeping	33,249	5,356		38,605		38,605	25	38,630		3
4	Laundry	14,224	3,049		17,273		17,273		17,273		4
5	Heat and Other Utilities			27,370	27,370		27,370	102	27,472		5
6	Maintenance	22,791	16,767	2,421	41,979		41,979	1,903	43,882		6
7	Other (specify):* Home Ofc. Benefit							478	478		7
8	TOTAL General Services	127,744	63,847	35,418	227,009		227,009	(561)	226,448		8
	B. Health Care and Programs										
9	Medical Director			10,200	10,200		10,200		10,200		9
10	Nursing and Medical Records	327,689	30,009	465	358,163		358,163	2,371	360,534		10
10a	Therapy			10,509	10,509		10,509	182	10,691		10a
11	Activities	11,311	1,016	3,100	15,427		15,427		15,427		11
12	Social Services	23,802	70		23,872		23,872		23,872		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Ofc. Benefit							746	746		15
16	TOTAL Health Care and Programs	362,802	31,095	24,274	418,171		418,171	3,299	421,470		16
	C. General Administration										
17	Administrative	49,686		15,500	65,186		65,186	(9,627)	55,559		17
18	Directors Fees										18
19	Professional Services			2,746	2,746		2,746	3,193	5,939		19
20	Dues, Fees, Subscriptions & Promotions			2,573	2,573		2,573	378	2,951		20
21	Clerical & General Office Expenses	8,333	3,791	10,769	22,893		22,893	9,708	32,601		21
22	Employee Benefits & Payroll Taxes			89,899	89,899		89,899	3,789	93,688		22
23	Inservice Training & Education			241	241		241	71	312		23
24	Travel and Seminar							204	204		24
25	Other Admin. Staff Transportation			3,823	3,823		3,823	833	4,656		25
26	Insurance-Prop.Liab.Malpractice			7,594	7,594		7,594	436	8,030		26
27	Other (specify):* Home Ofc. Benefit							2,125	2,125		27
28	TOTAL General Administration	58,019	3,791	133,145	194,955		194,955	11,110	206,065		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	548,565	98,733	192,837	840,135		840,135	13,848	853,983		29

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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

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			14,257	14,257		14,257	2,451	16,708			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			22,330	22,330		22,330	6,743	29,073			32
33	Real Estate Taxes			9,000	9,000		9,000	763	9,763			33
34	Rent-Facility & Grounds							348	348			34
35	Rent-Equipment & Vehicles			8,587	8,587		8,587	227	8,814			35
36	Other (specify):*											36
37	TOTAL Ownership			54,174	54,174		54,174	10,532	64,706			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			517	517		517		517			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			19,163	19,163		19,163		19,163			42
43	Other (specify):* Nonallowable Cost			4,889	4,889		4,889	(4,889)				43
44	TOTAL Special Cost Centers			24,569	24,569		24,569	(4,889)	19,680			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	548,565	98,733	271,580	918,878		918,878	19,491	938,369			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.

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	(455)	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	(122)	30		9
10	Interest and Other Investment Income	(1,190)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(48)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(5)	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				24
25	Fund Raising, Advertising and Promotional	(2,124)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule (See Page 5a)	(5,857)	Var		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (9,801)		\$	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)	29,292	Var	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 29,292		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 19,491		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	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY					
48		49		50	
				51	
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Cisne Rehabilitation & Health Care Center

ID# 0047423

Report Period Beginning: 01/01/06

Ending: 12/31/06

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Nonallowable marketing events	\$ (533)	43	1
2	Labs - Part A	(70)	43	2
3	Offset meal revenue	(76)	2	3
4	Special events	(1,654)	43	4
5	Offset misc revenue	(1,240)	21	5
6	Nonallowable architect fees	(171)	19	6
7	Nonallowable travel expense	(2,113)	24	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				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	Total	(5,857)		49

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Cisne Rehabilitation & Health Care Center# 0047423

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	549	0	218	0	0	0	0	0	0	0	767	1
2	Food Purchase	(76)	27	0	2	0	0	0	0	0	0	0	(47)	2
3	Housekeeping	0	24	0	1	0	0	0	0	0	0	0	25	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	102	0	0	0	0	0	0	0	0	0	102	5
6	Maintenance	0	1,397	0	506	0	0	0	0	0	0	0	1,903	6
7	Other (specify):*	0	220	0	258	0	0	0	0	0	0	0	478	7
8	TOTAL General Services	(76)	2,319	0	985	0	3,228	8						
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	1,986	0	385	0	0	0	0	0	0	0	2,371	10
10a	Therapy	0	182	0	0	0	0	0	0	0	0	0	182	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	614	0	132	0	0	0	0	0	0	0	746	15
16	TOTAL Health Care and Programs	0	2,782	0	517	0	3,299	16						
	C. General Administration													
17	Administrative	0	(10,086)	0	459	0	0	0	0	0	0	0	(9,627)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(171)	2,371	0	993	0	0	0	0	0	0	0	3,193	19
20	Fees, Subscriptions & Promotions	0	232	0	146	0	0	0	0	0	0	0	378	20
21	Clerical & General Office Expenses	(1,240)	0	8,728	2,220	0	0	0	0	0	0	0	9,708	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	71	0	0	0	0	0	0	0	0	71	23
24	Travel and Seminar	(2,113)	0	2,113	204	0	0	0	0	0	0	0	204	24
25	Other Admin. Staff Transportation	0	0	562	271	0	0	0	0	0	0	0	833	25
26	Insurance-Prop.Liab.Malpractice	0	0	416	20	0	0	0	0	0	0	0	436	26
27	Other (specify):*	0	0	1,542	583	0	0	0	0	0	0	0	2,125	27
28	TOTAL General Administration	(3,524)	(7,483)	13,432	4,896	0	7,321	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(3,600)	(2,382)	13,432	6,398	0	13,848	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Cisne Rehabilitation & Health Care Center# 0047423

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(122)	0	2,152	421	0	0	0	0	0	0	0	2,451	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,190)	0	1,195	6,738	0	0	0	0	0	0	0	6,743	32
33	Real Estate Taxes	0	0	252	511	0	0	0	0	0	0	0	763	33
34	Rent-Facility & Grounds	0	0	245	103	0	0	0	0	0	0	0	348	34
35	Rent-Equipment & Vehicles	0	0	128	99	0	0	0	0	0	0	0	227	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(1,312)	0	3,972	7,872	0	10,532	37						
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(4,889)	0	0	0	0	0	0	0	0	0	0	(4,889)	43
44	TOTAL Special Cost Centers	(4,889)	0	0	0	0	0	0	0	0	0	0	(4,889)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(9,801)	(2,382)	17,404	14,270	0	19,491	45						

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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 549	\$ 549	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	27	27	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	24	24	3
4	V							4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	102	102	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	1,397	1,397	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	220	220	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	1,986	1,986	8
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	182	182	9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	614	614	10
11	V	17 Administrative	15,500	Petersen Health Care, Inc.	100.00%	5,414	(10,086)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	2,371	2,371	12
13	V	20 Due, Fees, Subs & Promos		Petersen Health Care, Inc.	100.00%	232	232	13
14	Total		\$ 15,500			\$ 13,118	\$ * (2,382)	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%	\$ 8,728	\$	8,728	15
16	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	71		71	16
17	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	2,113		2,113	17
18	V	25 Other Admin. Staff Transport		Petersen Health Care, Inc.	100.00%	562		562	18
19	V	26 Insurance-Prop.Liab.Malpractice		Petersen Health Care, Inc.	100.00%	416		416	19
20	V	27 Mgmt Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,542		1,542	20
21	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	2,152		2,152	21
22	V	32 Interest		Petersen Health Care, Inc.	100.00%	1,195		1,195	22
23	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	252		252	23
24	V	34 Rent - Facility & Grounds		Petersen Health Care, Inc.	100.00%	245		245	24
25	V	35 Rent - Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	128		128	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		\$			\$ 17,404	\$ *	17,404	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1 <u>Dietary</u>	\$	<u>Petersen Health Care, Inc.</u>	100.00%	\$ 218	\$	218	15
16	V	2 <u>Food</u>		<u>Petersen Health Care, Inc.</u>	100.00%	2		2	16
17	V	3 <u>Housekeeping</u>		<u>Petersen Health Care, Inc.</u>	100.00%	1		1	17
18	V								18
19	V								19
20	V	6 <u>Maintenance</u>		<u>Petersen Health Care, Inc.</u>	100.00%	506		506	20
21	V	7 <u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Care, Inc.</u>	100.00%	258		258	21
22	V	10 <u>Nursing and Medical Records</u>		<u>Petersen Health Care, Inc.</u>	100.00%	385		385	22
23	V								23
24	V	15 <u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Care, Inc.</u>	100.00%	132		132	24
25	V	17 <u>Administrative</u>		<u>Petersen Health Care, Inc.</u>	100.00%	459		459	25
26	V	19 <u>Professional Services</u>		<u>Petersen Health Care, Inc.</u>	100.00%	993		993	26
27	V	20 <u>Due, Fees, Subs & Promos</u>		<u>Petersen Health Care, Inc.</u>	100.00%	146		146	27
28	V	21 <u>Clerical & General Office</u>		<u>Petersen Health Care, Inc.</u>	100.00%	2,220		2,220	28
29	V								29
30	V	24 <u>Travel and Seminar</u>		<u>Petersen Health Care, Inc.</u>	100.00%	204		204	30
31	V	25 <u>Other Admin. Staff Transport</u>		<u>Petersen Health Care, Inc.</u>	100.00%	271		271	31
32	V	26 <u>Insurance-Prop.Liab.Malpractice</u>		<u>Petersen Health Care, Inc.</u>	100.00%	20		20	32
33	V	27 <u>Mgmt Allocation of Benefits</u>		<u>Petersen Health Care, Inc.</u>	100.00%	583		583	33
34	V	30 <u>Depreciation</u>		<u>Petersen Health Care, Inc.</u>	100.00%	421		421	34
35	V	32 <u>Interest</u>		<u>Petersen Health Care, Inc.</u>	100.00%	6,738		6,738	35
36	V	33 <u>Real Estate Taxes</u>		<u>Petersen Health Care, Inc.</u>	100.00%	511		511	36
37	V	34 <u>Rent - Facility & Grounds</u>		<u>Petersen Health Care, Inc.</u>	100.00%	103		103	37
38	V	35 <u>Due, Fees, Subs & Promos</u>		<u>Petersen Health Care, Inc.</u>	100.00%	99		99	38
39	Total		\$			\$ 14,270	\$ *	14,270	39

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

Facility Name & ID Number Cisne Rehabilitation & Health Care Center # 0047423 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	0.34	0.68	Salary	\$ 5,414	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	\$ 5,414		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 Cisne Rehabilitation & Health Care Center# 0047423

Report Period Beginning:

01/01/06Ending: 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

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

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

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	<u>1</u>	<u>Dietary</u>	<u>Patient Days</u>	<u>1,141,463</u>	<u>56</u>	<u>\$ 81,179</u>	<u>\$ 80,967</u>	<u>7,725</u>	<u>\$ 549</u>	<u>1</u>
2	<u>2</u>	<u>Food</u>	<u>Patient Days</u>	<u>1,141,463</u>	<u>56</u>	<u>3,989</u>	<u>7,725</u>	<u>27</u>	<u>2</u>	
3	<u>3</u>	<u>Housekeeping</u>	<u>Patient Days</u>	<u>1,141,463</u>	<u>56</u>	<u>3,589</u>	<u>7,725</u>	<u>24</u>	<u>3</u>	
4	<u>4</u>								<u>4</u>	
5	<u>5</u>	<u>Utilities</u>	<u>Patient Days</u>	<u>1,141,463</u>	<u>56</u>	<u>15,054</u>	<u>7,725</u>	<u>102</u>	<u>5</u>	
6	<u>6</u>	<u>Maintenance</u>	<u>Patient Days</u>	<u>1,141,463</u>	<u>56</u>	<u>206,416</u>	<u>110,513</u>	<u>7,725</u>	<u>1,397</u>	<u>6</u>
7	<u>7</u>	<u>Mgmt. Allocation of Benefits</u>	<u>Patient Days</u>	<u>1,141,463</u>	<u>56</u>	<u>32,526</u>	<u>7,725</u>	<u>220</u>	<u>7</u>	
8	<u>10</u>	<u>Nursing and Medical Records</u>	<u>Patient Days</u>	<u>1,141,463</u>	<u>56</u>	<u>293,462</u>	<u>289,197</u>	<u>7,725</u>	<u>1,986</u>	<u>8</u>
9	<u>10A</u>	<u>Therapy</u>	<u>Patient Days</u>	<u>1,141,463</u>	<u>56</u>	<u>26,945</u>	<u>7,725</u>	<u>182</u>	<u>9</u>	
10	<u>15</u>	<u>Mgmt. Allocation of Benefits</u>	<u>Patient Days</u>	<u>1,141,463</u>	<u>56</u>	<u>90,724</u>	<u>7,725</u>	<u>614</u>	<u>10</u>	
11	<u>17</u>	<u>Administrative</u>	<u>Patient Days</u>	<u>1,141,463</u>	<u>56</u>	<u>800,000</u>	<u>800,000</u>	<u>7,725</u>	<u>5,414</u>	<u>11</u>
12	<u>19</u>	<u>Professional Services</u>	<u>Patient Days</u>	<u>1,141,463</u>	<u>56</u>	<u>350,361</u>	<u>7,725</u>	<u>2,371</u>	<u>12</u>	
13	<u>20</u>	<u>Due, Fees, Subs & Promos</u>	<u>Patient Days</u>	<u>1,141,463</u>	<u>56</u>	<u>34,325</u>	<u>7,725</u>	<u>232</u>	<u>13</u>	
14	<u>21</u>	<u>Clerical & General Office</u>	<u>Patient Days</u>	<u>1,141,463</u>	<u>56</u>	<u>1,289,623</u>	<u>954,322</u>	<u>7,725</u>	<u>8,728</u>	<u>14</u>
15	<u>23</u>	<u>Inservice Training & Education</u>	<u>Patient Days</u>	<u>1,141,463</u>	<u>56</u>	<u>10,426</u>	<u>7,725</u>	<u>71</u>	<u>15</u>	
16	<u>24</u>	<u>Travel and Seminar</u>	<u>Patient Days</u>	<u>1,141,463</u>	<u>56</u>	<u>312,259</u>	<u>7,725</u>	<u>2,113</u>	<u>16</u>	
17	<u>25</u>	<u>Other Admin. Staff Transport</u>	<u>Patient Days</u>	<u>1,141,463</u>	<u>56</u>	<u>83,062</u>	<u>7,725</u>	<u>562</u>	<u>17</u>	
18	<u>26</u>	<u>Insurance-Prop.Liab.Malpractice</u>	<u>Patient Days</u>	<u>1,141,463</u>	<u>56</u>	<u>61,457</u>	<u>7,725</u>	<u>416</u>	<u>18</u>	
19	<u>27</u>	<u>Mgmt Allocation of Benefits</u>	<u>Patient Days</u>	<u>1,141,463</u>	<u>56</u>	<u>227,912</u>	<u>7,725</u>	<u>1,542</u>	<u>19</u>	
20	<u>30</u>	<u>Depreciation</u>	<u>Patient Days</u>	<u>1,141,463</u>	<u>56</u>	<u>317,964</u>	<u>7,725</u>	<u>2,152</u>	<u>20</u>	
21	<u>32</u>	<u>Interest</u>	<u>Patient Days</u>	<u>1,141,463</u>	<u>56</u>	<u>176,614</u>	<u>7,725</u>	<u>1,195</u>	<u>21</u>	
22	<u>33</u>	<u>Real Estate Taxes</u>	<u>Patient Days</u>	<u>1,141,463</u>	<u>56</u>	<u>37,282</u>	<u>7,725</u>	<u>252</u>	<u>22</u>	
23	<u>34</u>	<u>Rent - Facility & Grounds</u>	<u>Patient Days</u>	<u>1,141,463</u>	<u>56</u>	<u>36,133</u>	<u>7,725</u>	<u>245</u>	<u>23</u>	
24	<u>35</u>	<u>Rent - Equipment & Vehicles</u>	<u>Patient Days</u>	<u>1,141,463</u>	<u>56</u>	<u>18,933</u>	<u>7,725</u>	<u>128</u>	<u>24</u>	
25	TOTALS					\$ 4,510,235	\$ 2,234,999		\$ 30,522	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cisne Rehabilitation & Health Care Center

0047423

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	<u>1</u>	<u>Dietary</u>	<u>Patient Days</u>	<u>427,669</u>	<u>46</u>	<u>\$ 12,081</u>	<u>\$ 11,958</u>	<u>7,725</u>	<u>\$ 218</u>	<u>1</u>
2	<u>2</u>	<u>Food</u>	<u>Patient Days</u>	<u>427,669</u>	<u>46</u>	<u>93</u>	<u>7,725</u>	<u>2</u>	<u>2</u>	
3	<u>3</u>	<u>Housekeeping</u>	<u>Patient Days</u>	<u>427,669</u>	<u>46</u>	<u>28</u>	<u>7,725</u>	<u>1</u>	<u>3</u>	
4									<u>4</u>	
5									<u>5</u>	
6	<u>6</u>	<u>Maintenance</u>	<u>Patient Days</u>	<u>427,669</u>	<u>46</u>	<u>28,012</u>	<u>28,012</u>	<u>7,725</u>	<u>506</u>	<u>6</u>
7	<u>7</u>	<u>Mgmt. Allocation of Benefits</u>	<u>Patient Days</u>	<u>427,669</u>	<u>46</u>	<u>14,282</u>	<u>7,725</u>	<u>258</u>	<u>7</u>	
8	<u>10</u>	<u>Nursing and Medical Records</u>	<u>Patient Days</u>	<u>427,669</u>	<u>46</u>	<u>21,299</u>	<u>20,434</u>	<u>7,725</u>	<u>385</u>	<u>8</u>
9									<u>9</u>	
10	<u>15</u>	<u>Mgmt. Allocation of Benefits</u>	<u>Patient Days</u>	<u>427,669</u>	<u>46</u>	<u>7,301</u>	<u>7,725</u>	<u>132</u>	<u>10</u>	
11	<u>17</u>	<u>Administrative</u>	<u>Patient Days</u>	<u>427,669</u>	<u>46</u>	<u>25,391</u>	<u>25,391</u>	<u>7,725</u>	<u>459</u>	<u>11</u>
12	<u>19</u>	<u>Professional Services</u>	<u>Patient Days</u>	<u>427,669</u>	<u>46</u>	<u>54,971</u>	<u>7,725</u>	<u>993</u>	<u>12</u>	
13	<u>20</u>	<u>Due, Fees, Subs & Promos</u>	<u>Patient Days</u>	<u>427,669</u>	<u>46</u>	<u>8,088</u>	<u>7,725</u>	<u>146</u>	<u>13</u>	
14	<u>21</u>	<u>Clerical & General Office</u>	<u>Patient Days</u>	<u>427,669</u>	<u>46</u>	<u>122,893</u>	<u>64,907</u>	<u>7,725</u>	<u>2,220</u>	<u>14</u>
15									<u>15</u>	
16	<u>24</u>	<u>Travel and Seminar</u>	<u>Patient Days</u>	<u>427,669</u>	<u>46</u>	<u>11,280</u>	<u>7,725</u>	<u>204</u>	<u>16</u>	
17	<u>25</u>	<u>Other Admin. Staff Transport</u>	<u>Patient Days</u>	<u>427,669</u>	<u>46</u>	<u>15,003</u>	<u>7,725</u>	<u>271</u>	<u>17</u>	
18	<u>26</u>	<u>Insurance-Prop.Liab.Malpractice</u>	<u>Patient Days</u>	<u>427,669</u>	<u>46</u>	<u>1,087</u>	<u>7,725</u>	<u>20</u>	<u>18</u>	
19	<u>27</u>	<u>Mgmt Allocation of Benefits</u>	<u>Patient Days</u>	<u>427,669</u>	<u>46</u>	<u>32,265</u>	<u>7,725</u>	<u>583</u>	<u>19</u>	
20	<u>30</u>	<u>Depreciation</u>	<u>Patient Days</u>	<u>427,669</u>	<u>46</u>	<u>23,301</u>	<u>7,725</u>	<u>421</u>	<u>20</u>	
21	<u>32</u>	<u>Interest</u>	<u>Patient Days</u>	<u>427,669</u>	<u>46</u>	<u>373,049</u>	<u>7,725</u>	<u>6,738</u>	<u>21</u>	
22	<u>33</u>	<u>Real Estate Taxes</u>	<u>Patient Days</u>	<u>427,669</u>	<u>46</u>	<u>28,282</u>	<u>7,725</u>	<u>511</u>	<u>22</u>	
23	<u>34</u>	<u>Rent - Facility & Grounds</u>	<u>Patient Days</u>	<u>427,669</u>	<u>46</u>	<u>5,700</u>	<u>7,725</u>	<u>103</u>	<u>23</u>	
24	<u>35</u>	<u>Rent - Equipment & Vehicles</u>	<u>Patient Days</u>	<u>427,669</u>	<u>46</u>	<u>5,479</u>	<u>7,725</u>	<u>99</u>	<u>24</u>	
25	TOTALS					\$ 789,885	\$ 150,702		\$ 14,270	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	LaSalle Bank		X	Mortgage	Varies	9/30/05	\$ 190,000	\$ 187,226	9/20/2010	Varies	\$ 18,330	1								
2	Ziegler Healthcare		X	Mortgage	Varies	9/30/05	40,000	39,927	9/20/2010	0.1000	4,000	2								
3												3								
4							Allocated from Home Office				7,933	4								
5							Interest Income Offset				(1,190)	5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related						\$ 230,000	\$ 227,153			\$ 29,073	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 230,000	\$ 227,153			\$ 29,073	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

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

1. Real Estate Tax accrual used on 2005 report.		\$	8,946	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.)	2005	\$	8,946	2
3. Under or (over) accrual (line 2 minus line 1).		\$		3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	9,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	763	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	9,763	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2001	_____	8	
	2002	_____	9	
	2003	_____	10	
	2004	_____	11	
	2005	8,946	12	
FOR BHF USE ONLY				
	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
Accrual based on minimal increase over prior year tax bill.				

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 Cisne Rehabilitation & Health Care Center COUNTY Wayne

FACILITY IDPH LICENSE NUMBER 0074423

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>03-50-065-006-00</u>	<u>Nursing Home</u>	\$ <u>81.90</u>	\$ <u>81.90</u>
2. <u>03-50-065-005</u>	<u>Nursing Home</u>	\$ <u>8,863.88</u>	\$ <u>8,863.88</u>
3. _____	<u>Home Office Allocation</u>	\$ _____	\$ <u>763.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>8,945.78</u>	\$ <u>9,708.78</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 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 Cisne Rehabilitation & Health Care Center

0047423

Report Period Beginning:

01/01/06

Ending:

12/31/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 9,413 B. General Construction Type: Exterior BRICK VENEER Frame WOOD Number of Stories 1

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

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

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

N/A

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>FACILITY</u>	<u>75,359</u>	<u>2005</u>	<u>\$ 9,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	75,359		\$ 9,000	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 BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	35	2005	1970	\$ 176,500	\$	25	\$ 7,060	\$ 7,060	\$ 10,590	4
5										5
6	Allocated from Home Office		2006	4,607			202	202	202	6
7										7
8										8
Improvement Type**										
9	ORIGINAL LAND IMPROVEMENTS		2005	10,000		15	667	667	1,000	9
10	WATERLINE		2005	1,634		15	109	109	163	10
11	CARPET		2006	1,269		5	127	127	127	11
12	GUTTER		2006	2,750		25	55	55	55	12
13	LAND IMPROVEMENT BOOKED				776			(776)		13
14	BUILDING BOOKED				7,090			(7,090)		14
15	BUILDING IMPROVEMENT BOOKED				259			(259)		15
16										16
17										17
18	Allocated from home office -Land and Improvements		2006	266			25	25	25	18
19	Allocated from home office-Leasehold Improvements		2006	8			1	1	1	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

*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.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 37,300	\$ 6,132	\$ 5,862	\$ (270)	5-7	\$ 8,793	71
72	Current Year Purchases	2,152		255	255	5	255	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			2,345	2,345			74
75	TOTALS	\$ 39,452	\$ 6,132	\$ 8,462	\$ 2,330		\$ 9,048	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78		N/A								78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 245,486	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 14,257	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 16,708	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,451	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 21,211	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	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? YES NO

If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6	Home Office Allocation				348			6
7	TOTAL				\$ 348			7

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 N/A.

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: \$ 8,814 Description: COPIER \$2036, WASHER \$841, MAINT \$29, NURSING \$5615, LAUNDRY \$66, HOME OFC. \$227

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. /2007 \$ N/A

13. /2008 \$ N/A

14. /2009 \$ N/A

* 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.

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- 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	\$	59	\$ 4,755	\$	59	\$ 4,755	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		17	1,494		17	1,494	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3), (7)	hrs		55	4,260	182	55	4,442	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	39(3)			13	517		13	517	12
13	Other (specify):									13
14	TOTAL			\$	144	\$ 11,026	\$ 182	144	\$ 11,208	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

Facility Name & ID Number Cisne Rehabilitation & Health Care Center

0047423

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	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 325	\$ 325	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>None</u>)	122,208	122,208	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	7,370	7,370	7
8	Accounts Receivable (owners or related parties)	2,616	2,616	8
9	Other(specify): _____			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 132,519	\$ 132,519	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	20,634	9,000	13
14	Buildings, at Historical Cost	180,519	197,034	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	39,452	39,452	16
17	Accumulated Depreciation (book methods)	(16,631)	(21,211)	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): _____			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 223,974	\$ 224,275	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 356,493	\$ 356,794	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 366,422	\$ 366,422	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	10,264	10,264	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,330	4,330	31
32	Accrued Real Estate Taxes(Sch.IX-B)	9,000	9,000	32
33	Accrued Interest Payable	2,387	2,387	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Withholdings</u>	4,519	4,519	36
37	_____			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 396,922	\$ 396,922	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	39,927	39,927	39
40	Mortgage Payable	187,226	187,226	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)	\$ 227,153	\$ 227,153	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 624,075	\$ 624,075	46
47	TOTAL EQUITY (page 18, line 24)	\$ (267,582)	\$ (267,281)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 356,493	\$ 356,794	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (65,832)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (65,832)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(201,751)	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) Rounding	1	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (201,750)	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)	\$ (267,582)	24 *

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 714,346	1
2	Discounts and Allowances for all Levels	275	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 714,621	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	76	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 76	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,190	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,190	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Misc.</u>	1,240	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,240	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 717,127	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	227,009	31
32	Health Care	418,171	32
33	General Administration	194,955	33
	B. Capital Expense		
34	Ownership	54,174	34
	C. Ancillary Expense		
35	Special Cost Centers	5,406	35
36	Provider Participation Fee	19,163	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 918,878	40
41	Income before Income Taxes (line 30 minus line 40)**	(201,751)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (201,751)	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 Cisne Rehabilitation & Health Care Center

0047423

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	780	\$ 14,982	\$ 19.21	1
2	Assistant Director of Nursing				2
3	Registered Nurses	4,022	71,239	17.71	3
4	Licensed Practical Nurses	4,929	80,928	15.50	4
5	CNAs & Orderlies	14,769	137,754	9.33	5
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director	1,129	11,311	10.02	9
10	Activity Assistants				10
11	Social Service Workers	2,080	23,802	11.44	11
12	Dietician				12
13	Food Service Supervisor	2,033	22,039	10.84	13
14	Head Cook				14
15	Cook Helpers/Assistants	5,320	35,441	6.66	15
16	Dishwashers				16
17	Maintenance Workers	2,010	22,791	11.34	17
18	Housekeepers	4,310	33,249	7.71	18
19	Laundry	1,817	14,224	7.61	19
20	Administrator	2,184	49,686	22.26	20
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager	873	8,333	9.55	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 C: <u>Care Plan Coord</u>	1,323	22,786	17.23	32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	47,578	\$ 548,565 *	\$ 11.44	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	83	\$ 5,627	1,3	35
36	Medical Director	monthly	10,200	9,3	36
37	Medical Records Consultant	1 visit	20	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	445	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)	83	\$ 16,292		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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
<u>Erin Billington</u>	<u>Administrator</u>	<u>0</u>	\$ <u>41,088</u>	<u>Workers' Compensation Insurance</u>	\$ <u>12,624</u>	<u>IDPH License Fee</u>	\$ <u>1,469</u>	
<u>Thomas Selders</u>	<u>Administrator</u>	<u>0</u>	<u>8,015</u>	<u>Unemployment Compensation Insurance</u>	<u>33,949</u>	<u>Advertising: Employee Recruitment</u>	<u>79</u>	
<u>Jane Owens</u>	<u>Administrator</u>	<u>0</u>	<u>583</u>	<u>FICA Taxes</u>	<u>40,411</u>	<u>Health Care Worker Background Check</u>	<u>750</u>	
				<u>Employee Health Insurance</u>	<u>193</u>	(Indicate # of checks performed <u>75</u>)		
				<u>Employee Meals</u>	<u>3,789</u>	<u>Patient Background Checks</u>		
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Misc Dues and Subscriptions</u>	<u>275</u>	
				<u>Employee Retirement</u>	<u>39</u>	<u>Home Office Allocation</u>	<u>378</u>	
				<u>Employee Relations</u>	<u>2,683</u>			
TOTAL (agree to Schedule V, line 17, col. 1)			\$ <u>49,686</u>					
(List each licensed administrator separately.)								
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
<u>Management Fee (eliminated in Col. 7)</u>			\$ <u>15,500</u>	<u>N/A</u>			<u>Out-of-State Travel</u>	\$
							<u>In-State Travel</u>	
							<u>Seminar Expense</u>	
							<u>Home Office Allocation</u>	<u>204</u>
TOTAL (agree to Schedule V, line 17, col. 3)			\$ <u>15,500</u>				<u>Entertainment Expense</u>	()
(Attach a copy of any management service agreement)							(agree to Sch. V, line 24, col. 8)	
C. Professional Services				TOTAL			TOTAL	
Vendor/Payee	Type			Amount				
<u>Wabash Independent Networks</u>	<u>Computer Services</u>			<u>896</u>				
<u>LTC Solutions</u>	<u>Computer Services</u>			<u>1,850</u>				
TOTAL (agree to Schedule V, line 19, column 3)			\$ <u>2,746</u>	\$				
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Cisne Rehabilitation & Health Care Center
Provider Number - 0047423
FYE: 12/31/2006

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Total (agree to Schedule V, line 19, column 3) 2,746

Allocated from Home Office

Other Professional Fees	2,340
Legal	31
Other Professional Fees - PHO	963
Legal - PHO	30
Home Office Architect Fee Offset, per Sch VI	<u>(171)</u>

Total (agree to Schedule V, line 19, column 8) 5,939

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	5-13 Amount of Expense Amortized Per Year								
					6 FY2003	7 FY2004	8 FY2005	9 FY2006	10 FY2007	11 FY2008	12 FY2009	13 FY2010	14 FY2011
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5	N/A												
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Cisne Rehabilitation & Health Care Center# 0047423

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? 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? 5 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 2,573 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. \$ 19,163
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.

SEE ACCOUNTANTS' COMPILATION REPORT

- (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. \$ 3,789 Has any meal income been offset against related costs? Y Indicate the amount. \$ 76
- (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? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
- 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 currently in progress
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$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