

Facility Name & ID Number Decatur Rehabilitation & Health Care Center

0047449 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	58	Intermediate (ICF)	58	21,170	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	58	TOTALS	58	21,170	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			
		2 Medicaid Recipient	3 Private Pay	4 Other	
8	SNF				8
9	SNF/PED				9
10	ICF	15,588	267	445	16,300
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	15,588	267	445	16,300

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.00%

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 10/1/05

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

YES Date 10/1/05 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 Decatur Rehabilitation & Health Care Center # 0047449 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	88,714	6,344		95,058		95,058	1,619	96,677		1
2	Food Purchase		74,257		74,257		74,257	(4,726)	69,531		2
3	Housekeeping	77,912	15,494		93,406		93,406	52	93,458		3
4	Laundry	12,838	13,674		26,512		26,512		26,512		4
5	Heat and Other Utilities			43,740	43,740		43,740	215	43,955		5
6	Maintenance	24,625	20,746	10,106	55,477		55,477	4,016	59,493		6
7	Other (specify):* Home Ofc. Benefits							1,008	1,008		7
8	TOTAL General Services	204,089	130,515	53,846	388,450		388,450	2,184	390,634		8
	B. Health Care and Programs										
9	Medical Director			13,000	13,000		13,000		13,000		9
10	Nursing and Medical Records	487,738	40,956	929	529,623		529,623	5,003	534,626		10
10a	Therapy			11,352	11,352		11,352	385	11,737		10a
11	Activities	24,705	1,873	1,292	27,870		27,870		27,870		11
12	Social Services	22,408			22,408		22,408		22,408		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Ofc. Benefits							1,574	1,574		15
16	TOTAL Health Care and Programs	534,851	42,829	26,573	604,253		604,253	6,962	611,215		16
	C. General Administration										
17	Administrative	63,667		33,000	96,667		96,667	(20,608)	76,059		17
18	Directors Fees										18
19	Professional Services			1,904	1,904		1,904	6,736	8,640		19
20	Dues, Fees, Subscriptions & Promotions			4,531	4,531		4,531	798	5,329		20
21	Clerical & General Office Expenses	30,026	4,472	7,688	42,186		42,186	22,713	64,899		21
22	Employee Benefits & Payroll Taxes			133,430	133,430		133,430	3,743	137,173		22
23	Inservice Training & Education			938	938		938	149	1,087		23
24	Travel and Seminar			10	10		10	430	440		24
25	Other Admin. Staff Transportation			2,434	2,434		2,434	1,758	4,192		25
26	Insurance-Prop.Liab.Malpractice			14,349	14,349		14,349	919	15,268		26
27	Other (specify):* Home Ofc. Benefits							4,485	4,485		27
28	TOTAL General Administration	93,693	4,472	198,284	296,449		296,449	21,123	317,572		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	832,633	177,816	278,703	1,289,152		1,289,152	30,269	1,319,421		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			22,164	22,164		22,164	5,570	27,734			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			36,588	36,588		36,588	13,537	50,125			32
33	Real Estate Taxes			27,800	27,800		27,800	1,610	29,410			33
34	Rent-Facility & Grounds							733	733			34
35	Rent-Equipment & Vehicles			8,113	8,113		8,113	479	8,592			35
36	Other (specify):*											36
37	TOTAL Ownership			94,665	94,665		94,665	21,929	116,594			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			44	44		44		44			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			31,755	31,755		31,755		31,755			42
43	Other (specify):* Nonallowable Cost			13,727	13,727		13,727	(13,727)				43
44	TOTAL Special Cost Centers			45,526	45,526		45,526	(13,727)	31,799			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	832,633	177,816	418,894	1,429,343		1,429,343	38,471	1,467,814			45

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(4,267)	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	141	30		9
10	Interest and Other Investment Income	(3,203)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(142)	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	(500)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(570)	43		24
25	Fund Raising, Advertising and Promotional	(3,311)	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	(11,189)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (23,041)	var	\$	30

BHF USE ONLY					
48		49		50	
				51	
					52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	61,512	var	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 61,512		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 38,471		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

SEE ACCOUNTANTS' COMPILATION REPORT

Decatur Rehabilitation & Health Care Center

ID# 0047449

Report Period Beginning: 01/01/06

Ending: 12/31/06

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Nonallowable marketing events	\$ (649)	43	1
2	Labs - Part A	(213)	43	2
3	Offset meal revenue	(1,044)	2	3
4	Special Events	(4,074)	43	4
5	Offset Misc Income	(388)	21	5
6	Nonallowable Architect Fee	(362)	19	6
7	Nonallowable Travel Expense	(4,459)	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	(11,189)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Decatur Rehabilitation & Health Care Center# 0047449

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	1,159	0	460	0	0	0	0	0	0	0	1,619	1
2	Food Purchase	(1,044)	57	0	4	0	0	0	0	0	0	0	(983)	2
3	Housekeeping	0	51	0	1	0	0	0	0	0	0	0	52	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	215	0	0	0	0	0	0	0	0	0	215	5
6	Maintenance	0	2,948	0	1,068	0	0	0	0	0	0	0	4,016	6
7	Other (specify):*	0	464	0	544	0	0	0	0	0	0	0	1,008	7
8	TOTAL General Services	(1,044)	4,894	0	2,077	0	5,927	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	4,191	0	812	0	0	0	0	0	0	0	5,003	10
10a	Therapy	0	385	0	0	0	0	0	0	0	0	0	385	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	1,296	0	278	0	0	0	0	0	0	0	1,574	15
16	TOTAL Health Care and Programs	0	5,872	0	1,090	0	6,962	16						
	C. General Administration													
17	Administrative	0	(21,576)	0	968	0	0	0	0	0	0	0	(20,608)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(362)	5,003	0	2,095	0	0	0	0	0	0	0	6,736	19
20	Fees, Subscriptions & Promotions	0	490	0	308	0	0	0	0	0	0	0	798	20
21	Clerical & General Office Expenses	(388)	0	18,416	4,684	0	0	0	0	0	0	0	22,712	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	149	0	0	0	0	0	0	0	0	149	23
24	Travel and Seminar	(4,459)	0	4,459	430	0	0	0	0	0	0	0	430	24
25	Other Admin. Staff Transportation	0	0	1,186	572	0	0	0	0	0	0	0	1,758	25
26	Insurance-Prop.Liab.Malpractice	0	0	878	41	0	0	0	0	0	0	0	919	26
27	Other (specify):*	0	0	3,255	1,230	0	0	0	0	0	0	0	4,485	27
28	TOTAL General Administration	(5,209)	(16,083)	28,343	10,328	0	17,379	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(6,253)	(5,317)	28,343	13,495	0	30,268	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Decatur Rehabilitation & Health Care Center # 0047449 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	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	141	0	4,541	888	0	0	0	0	0	0	0	5,570	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,203)	0	2,522	14,218	0	0	0	0	0	0	0	13,537	32
33	Real Estate Taxes	0	0	532	1,078	0	0	0	0	0	0	0	1,610	33
34	Rent-Facility & Grounds	0	0	516	217	0	0	0	0	0	0	0	733	34
35	Rent-Equipment & Vehicles	0	0	270	209	0	0	0	0	0	0	0	479	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(3,062)	0	8,381	16,610	0	21,929	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):*	(13,726)	0	0	0	0	0	0	0	0	0	0	(13,726)	43
44	TOTAL Special Cost Centers	(13,726)	0	0	0	0	0	0	0	0	0	0	(13,726)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(23,041)	(5,317)	36,724	30,105	0	38,471	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	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%	\$ 1,159	\$ 1,159	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	57	57	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	51	51	3
4	V							4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	215	215	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	2,948	2,948	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	464	464	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	4,191	4,191	8
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	385	385	9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,296	1,296	10
11	V	17 Administrative	33,000	Petersen Health Care, Inc.	100.00%	11,424	(21,576)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	5,003	5,003	12
13	V	20 Due, Fees, Subs & Promos		Petersen Health Care, Inc.	100.00%	490	490	13
14	Total		\$ 33,000			\$ 27,683	\$ * (5,317)	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%	\$ 18,416	\$	18,416	15
16	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	149		149	16
17	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	4,459		4,459	17
18	V	25 Other Admin. Staff Transport		Petersen Health Care, Inc.	100.00%	1,186		1,186	18
19	V	26 Insurance-Prop.Liab.Malpractice		Petersen Health Care, Inc.	100.00%	878		878	19
20	V	27 Mgmt Allocation of Benefits		Petersen Health Care, Inc.	100.00%	3,255		3,255	20
21	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	4,541		4,541	21
22	V	32 Interest		Petersen Health Care, Inc.	100.00%	2,522		2,522	22
23	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	532		532	23
24	V	34 Rent - Facility & Grounds		Petersen Health Care, Inc.	100.00%	516		516	24
25	V	35 Rent - Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	270		270	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		\$			\$ 36,724	\$ *	36,724	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%	\$ 460	\$	460	15
16	V	2 <u>Food</u>		<u>Petersen Health Care, Inc.</u>	100.00%	4		4	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%	1,068		1,068	20
21	V	7 <u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Care, Inc.</u>	100.00%	544		544	21
22	V	10 <u>Nursing and Medical Records</u>		<u>Petersen Health Care, Inc.</u>	100.00%	812		812	22
23	V	10A <u>Therapy</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0		0	23
24	V	15 <u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Care, Inc.</u>	100.00%	278		278	24
25	V	17 <u>Administrative</u>		<u>Petersen Health Care, Inc.</u>	100.00%	968		968	25
26	V	19 <u>Professional Services</u>		<u>Petersen Health Care, Inc.</u>	100.00%	2,095		2,095	26
27	V	20 <u>Due, Fees, Subs & Promos</u>		<u>Petersen Health Care, Inc.</u>	100.00%	308		308	27
28	V	21 <u>Clerical & General Office</u>		<u>Petersen Health Care, Inc.</u>	100.00%	4,684		4,684	28
29	V								29
30	V	24 <u>Travel and Seminar</u>		<u>Petersen Health Care, Inc.</u>	100.00%	430		430	30
31	V	25 <u>Other Admin. Staff Transport</u>		<u>Petersen Health Care, Inc.</u>	100.00%	572		572	31
32	V	26 <u>Insurance-Prop.Liab.Malpractice</u>		<u>Petersen Health Care, Inc.</u>	100.00%	41		41	32
33	V	27 <u>Mgmt Allocation of Benefits</u>		<u>Petersen Health Care, Inc.</u>	100.00%	1,230		1,230	33
34	V	30 <u>Depreciation</u>		<u>Petersen Health Care, Inc.</u>	100.00%	888		888	34
35	V	32 <u>Interest</u>		<u>Petersen Health Care, Inc.</u>	100.00%	14,218		14,218	35
36	V	33 <u>Real Estate Taxes</u>		<u>Petersen Health Care, Inc.</u>	100.00%	1,078		1,078	36
37	V	34 <u>Rent - Facility & Grounds</u>		<u>Petersen Health Care, Inc.</u>	100.00%	217		217	37
38	V	35 <u>Rent - Equipment & Vehicles</u>		<u>Petersen Health Care, Inc.</u>	100.00%	209		209	38
39	Total		\$			\$ 30,105	\$ *	30,105	39

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

Facility Name & ID Number Decatur Rehabilitation & Health Care Cente # 0047449 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	0.71	1.43	Salary	\$ 11,424	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	\$ 11,424		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 Decatur Rehabilitation & Health Care Center

0047449

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	\$ 80,967	16,300	\$ 1,159	1
2	2	Food	Patient Days	1,141,463	56	3,989		16,300	57	2
3	3	Housekeeping	Patient Days	1,141,463	56	3,589		16,300	51	3
4										4
5	5	Utilities	Patient Days	1,141,463	56	15,054		16,300	215	5
6	6	Maintenance	Patient Days	1,141,463	56	206,416	110,513	16,300	2,948	6
7	7	Mgmt. Allocation of Benefits	Patient Days	1,141,463	56	32,526		16,300	464	7
8	10	Nursing and Medical Records	Patient Days	1,141,463	56	293,462	289,197	16,300	4,191	8
9	10A	Therapy	Patient Days	1,141,463	56	26,945		16,300	385	9
10	15	Mgmt. Allocation of Benefits	Patient Days	1,141,463	56	90,724		16,300	1,296	10
11	17	Administrative	Patient Days	1,141,463	56	800,000	800,000	16,300	11,424	11
12	19	Professional Services	Patient Days	1,141,463	56	350,361		16,300	5,003	12
13	20	Due, Fees, Subs & Promos	Patient Days	1,141,463	56	34,325		16,300	490	13
14	21	Clerical & General Office	Patient Days	1,141,463	56	1,289,623	954,322	16,300	18,416	14
15	23	Inservice Training & Education	Patient Days	1,141,463	56	10,426		16,300	149	15
16	24	Travel and Seminar	Patient Days	1,141,463	56	312,259		16,300	4,459	16
17	25	Other Admin. Staff Transport	Patient Days	1,141,463	56	83,062		16,300	1,186	17
18	26	Insurance-Prop.Liab.Malpractice	Patient Days	1,141,463	56	61,457		16,300	878	18
19	27	Mgmt Allocation of Benefits	Patient Days	1,141,463	56	227,912		16,300	3,255	19
20	30	Depreciation	Patient Days	1,141,463	56	317,964		16,300	4,541	20
21	32	Interest	Patient Days	1,141,463	56	176,614		16,300	2,522	21
22	33	Real Estate Taxes	Patient Days	1,141,463	56	37,282		16,300	532	22
23	34	Rent - Facility & Grounds	Patient Days	1,141,463	56	36,133		16,300	516	23
24	35	Rent - Equipment & Vehicles	Patient Days	1,141,463	56	18,933		16,300	270	24
25	TOTALS					\$ 4,510,235	\$ 2,234,999		\$ 64,407	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Decatur Rehabilitation & Health Care Center

0047449

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>16,300</u>	<u>\$ 460</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>16,300</u>	<u>4</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>16,300</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>16,300</u>	<u>1,068</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>16,300</u>	<u>544</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>16,300</u>	<u>812</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>16,300</u>	<u>278</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>16,300</u>	<u>968</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>16,300</u>	<u>2,095</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>16,300</u>	<u>308</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>16,300</u>	<u>4,684</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>16,300</u>	<u>430</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>16,300</u>	<u>572</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>16,300</u>	<u>41</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>16,300</u>	<u>1,230</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>16,300</u>	<u>888</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>16,300</u>	<u>14,218</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>16,300</u>	<u>1,078</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>16,300</u>	<u>217</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>16,300</u>	<u>209</u>	<u>24</u>	
25	TOTALS					\$ 789,885	\$ 150,702		\$ 30,105	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	Name of Lender	2		3	4	5	6		7	8	9	10					
		Related**					Monthly Payment Required	Date of Note					Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
A. Directly Facility Related																	
Long-Term																	
1	LaSalle Bank		X	Mortgage	Varies	09/30/05	\$ 320,000	\$ 315,329	09/20/10	Varies	\$ 27,208	1					
2	Ziegler Healthcare		X	Mortgage	Varies	09/30/05	60,000	59,890	09/20/10	0.1000	9,380	2					
3												3					
4							Offset Interest Income				(3,203)	4					
5							Allocated from Home Office				16,740	5					
Working Capital																	
6												6					
7												7					
8												8					
9	TOTAL Facility Related						\$ 380,000	\$ 375,219			\$ 50,125	9					
B. Non-Facility Related*																	
10												10					
11												11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$	14					
15	TOTALS (line 9+line14)						\$ 380,000	\$ 375,219			\$ 50,125	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.		\$	27,708	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	\$	27,708	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.)		\$	27,800	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	Home Office Allocation	\$	1,610	7
			29,410	

Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2001	_____	8
	2002	_____	9
	2003	_____	10
	2004	_____	11
	2005	27,708	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

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 Decatur Rehabilitation & Health Care Center COUNTY Macon

FACILITY IDPH LICENSE NUMBER 0047449

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>04-12-17-254-003</u>	<u>Nursing Home</u>	\$ <u>27,707.52</u>	\$ <u>27,707.52</u>
2. _____	<u>Home Office Allocation</u>	\$ _____	\$ <u>1,610.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>27,707.52</u>	\$ <u>29,317.52</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 Decatur Rehabilitation & Health Care Center

0047449

Report Period Beginning:

01/01/06

Ending:

12/31/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 8,653 B. General Construction Type: Exterior BRICK Frame CONCRETE 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).

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>43,560</u>	<u>2005</u>	<u>\$ 37,500</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	43,560		\$ 37,500	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	58	2005	1970	\$ 275,500	\$	25	\$ 11,020	\$ 11,020	\$ 16,530
5									
6	Home Office Allocation		2006	9,721			425	425	425
7									
8									
Improvement Type**									
9	Original Land Improvements		2005	10,000		15	667	667	1,000
10	Sidewalks		2006	2,311		15	77	77	77
11									
12	Land Improvement Booked				769			(769)	
13	Building Booked				11,069			(11,069)	
14									
15	Home Office Allocation - Land Improvements		2006	562			52	52	52
16	Home Office Allocation - Building Improvements		2006	16			1	1	1
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

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

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

See Page 12A, Line 70 for total

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)	\$ 298,110	\$ 11,838		\$ 12,242	\$ 404	\$ 18,085	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	\$ 62,280	\$ 10,325	\$ 9,903	\$ (422)	8	\$ 14,854	71
72	Current Year Purchases	12,723		638	638	9.5	638	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			4,951	4,951			74
75	TOTALS	\$ 75,003	\$ 10,325	\$ 15,492	\$ 5,167		\$ 15,492	75

D. Vehicle Depreciation (See instructions.)*

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

E. Summary of Care-Related 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)	\$ 410,613	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 22,163	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 27,734	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 5,571	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 33,577	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88	N/A				88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

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

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

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

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	Home Office Allocation				733			6
7	TOTAL				\$ 733			7

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

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

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

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

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ 8,592 Description: Copier-1237,Dishwasher-889, Postage machine-11, Nurse-5976, Home Ofc.-479

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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.

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- 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	\$	72	\$ 5,770	\$	72	\$ 5,770	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		6	544		6	544	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		65	5,038		65	5,038	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)			1	44		1	44	12
13	Other (specify):									13
14	TOTAL			\$	144	\$ 11,396	\$	144	\$ 11,396	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 Decatur Rehabilitation & Health Care Center

0047449

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	\$ 8,112	\$ 8,112	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>None</u>)	218,155	218,155	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	8,406	8,406	7
8	Accounts Receivable (owners or related parties)	3,964	3,964	8
9	Other(specify): <u>Security Deposit</u>	6,045	6,045	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 244,682	\$ 244,682	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	49,811	37,500	13
14	Buildings, at Historical Cost	275,500	285,221	14
15	Leasehold Improvements, at Historical Cost		12,889	15
16	Equipment, at Historical Cost	75,003	75,003	16
17	Accumulated Depreciation (book methods)	(25,886)	(33,577)	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)	\$ 374,428	\$ 377,036	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 619,110	\$ 621,718	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 173,259	\$ 173,259	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	17,063	17,063	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,691	7,691	31
32	Accrued Real Estate Taxes(Sch.IX-B)	27,800	27,800	32
33	Accrued Interest Payable	3,903	3,903	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Withholdings</u>	6,985	6,985	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 236,701	\$ 236,701	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	59,890	59,890	39
40	Mortgage Payable	315,329	315,329	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)	\$ 375,219	\$ 375,219	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 611,920	\$ 611,920	46
47	TOTAL EQUITY(page 18, line 24)	\$ 7,190	\$ 9,798	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 619,110	\$ 621,718	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 32,202	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 32,202	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(25,010)	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	(2)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (25,012)	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)	\$ 7,190	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	\$ 1,394,545	1
2	Discounts and Allowances for all Levels	(1,164)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,393,381	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	5,818	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 5,818	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	499	13
14	Non-Patient Meals	1,044	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)	\$ 1,543	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	3,203	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,203	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc.	388	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 388	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,404,333	30

2

Expenses		Amount	
A. Operating Expenses			
31	General Services	388,450	31
32	Health Care	604,253	32
33	General Administration	296,449	33
B. Capital Expense			
34	Ownership	94,665	34
C. Ancillary Expense			
35	Special Cost Centers	13,771	35
36	Provider Participation Fee	31,755	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,429,343	40
41	Income before Income Taxes (line 30 minus line 40)**	(25,010)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (25,010)	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 Decatur Rehabilitation & Health Care Center

0047449

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	2,009	2,065	\$ 61,698	\$ 29.87	1
2	Assistant Director of Nursing					2
3	Registered Nurses	40	43	1,141	26.86	3
4	Licensed Practical Nurses	11,682	11,684	206,667	17.69	4
5	CNAs & Orderlies	22,755	23,004	218,231	9.49	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	479	479	10,837	22.61	9
10	Activity Assistants	1,534	1,534	13,868	9.04	10
11	Social Service Workers	3,572	3,641	22,408	6.15	11
12	Dietician					12
13	Food Service Supervisor	2,072	2,072	25,618	12.36	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,255	8,315	63,096	7.59	15
16	Dishwashers					16
17	Maintenance Workers	2,109	2,126	24,625	11.58	17
18	Housekeepers	9,657	9,683	77,912	8.05	18
19	Laundry	1,833	1,833	12,838	7.00	19
20	Administrator	2,080	2,080	63,667	30.61	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,010	2,027	30,026	14.81	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(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	70,088	70,586	\$ 832,633 *	\$ 11.80	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant			35	
36	Medical Director	monthly	13,000	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	929	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)		\$ 13,929		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			51
52	Certified Nurse Assistants/Aides	N/A		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	
Lynnette Green	Administrator	0	\$ 63,667	Workers' Compensation Insurance	\$ 21,140	IDPH License Fee	\$ 1,786	
				Unemployment Compensation Insurance	52,518	Advertising: Employee Recruitment	785	
				FICA Taxes	61,481	Health Care Worker Background Check (Indicate # of checks performed <u>178</u>)	1,782	
				Employee Health Insurance	(5,803)	Patient Background Checks		
				Employee Meals	3,743	Miscellaneous Licenses & Fees	63	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Dues & Subscriptions	115	
				Employee Relations	4,094	Allocated from Home Office	798	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 63,667			Less: Public Relations Expense	()	
B. Administrative - Other						Non-allowable advertising	()	
Description			Amount			Yellow page advertising	()	
Management Fee (eliminated in column 7)			\$ 33,000					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 33,000	TOTAL (agree to Schedule V, line 22, col.8)	\$ 137,173	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 5,329	
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 #	Description	Amount	
SBC	Computer Services		\$ 54			Out-of-State Travel	\$	
LTC Solutions	Computer Services		1,850					
				N/A		In-State Travel		
						Seminar Expense	10	
						Allocated from Home Office	430	
						Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 1,904	TOTAL	\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 440	

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Decatur Rehabilitation & Health Care Center
Provider Number - 0047449
FYE: 12/31/2006

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Total (agree to Schedule V, line 19, column 3) 1,904

Allocated from Home Office

Other Professional Fees	4,937	
Legal	66	
Other Professional Fees - PHO	2,033	
Legal - PHO	62	
Home Office Architect Fee Offset, per Sch VI	<u>(362)</u>	6,736

Total (agree to Schedule V, line 19, column 8) 8,640

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			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
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 Decatur Rehabilitation & Health Care Center# 0047449

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? 9.5 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,448 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. \$ 31,755
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. \$ 3,743 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,044
- (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?
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? 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