

		FOR BHF USE					

LL1

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

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

<p><b>I. IDPH Facility ID Number:</b> <u>0047159</u></p> <p><b>Facility Name:</b> <u>Effingham Rehabilitation &amp; Health Care Center</u></p> <p><b>Address:</b> <u>1610 North Lakewood Drive</u> <u>Effingham</u> <u>62401</u>          Number City Zip Code</p> <p><b>County:</b> <u>EFFINGHAM</u></p> <p><b>Telephone Number:</b> <u>(217) 347-7470</u> <b>Fax #</b> <u>(217) 342-2731</u></p> <p><b>HFS ID Number:</b> <u>200349783007</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>5/1/05</u></p> <p><b>Type of Ownership:</b></p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Christine A. Hanover</u> <b>Telephone Number:</b> <u>(312) 634-4581</u>  <b>Please send copies of desk review and audit adjustments to address on this page.</b></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/06</u> to <u>12/31/06</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="3" style="width: 15%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Type or Print Name) _____</td> </tr> <tr> <td></td> <td>(Title) _____</td> </tr> <tr> <td rowspan="5"><b>Paid Preparer</b></td> <td>(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u></td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> </tr> <tr> <td>(Firm Name &amp; Address) <u>McGladrey &amp; Pullen, LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u></td> </tr> <tr> <td>(Telephone) <u>(312) 384-6000</u> Fax # <u>(312) 634-5518</u></td> </tr> </table> <p><b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>  <b>201 S. Grand Avenue East</b>  <b>Springfield, IL 62763-0001</b> Phone # <u>(217) 782-1630</u></p>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____	(Type or Print Name) _____		(Title) _____	<b>Paid Preparer</b>	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u>	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) <u>McGladrey &amp; Pullen, LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u>	(Telephone) <u>(312) 384-6000</u> Fax # <u>(312) 634-5518</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																			
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																																			
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County																																			
<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____																																			
	<input type="checkbox"/> "Sub-S" Corp.																																				
	<input checked="" type="checkbox"/> Limited Liability Co.																																				
	<input type="checkbox"/> Trust																																				
	<input type="checkbox"/> Other _____																																				
<b>Officer or Administrator of Provider</b>	(Signed) _____																																				
	(Date) _____																																				
	(Type or Print Name) _____																																				
	(Title) _____																																				
<b>Paid Preparer</b>	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u>																																				
	(Date) _____																																				
	(Print Name and Title) _____																																				
	(Firm Name & Address) <u>McGladrey &amp; Pullen, LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u>																																				
	(Telephone) <u>(312) 384-6000</u> Fax # <u>(312) 634-5518</u>																																				

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Effingham Rehabilitation & Health Care Center

# 0047159 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	62	Skilled (SNF)	62	22,630	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	62	TOTALS	62	22,630	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	2,198	9,287	3,888	15,373	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	2,198	9,287	3,888	15,373	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.93%

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 05/01/05

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

YES  Date 05/01/05 NO

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

YES  NO  If YES, enter number of beds certified 16 and days of care provided 3,888

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

Is your fiscal year identical to your tax year? YES  NO

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	99,436	4,120	2,520	106,076		106,076	1,093	107,169		1
2	Food Purchase		75,469		75,469		75,469	(6,832)	68,637		2
3	Housekeeping	77,423	13,227		90,650		90,650	48	90,698		3
4	Laundry	24,863	10,332		35,195		35,195		35,195		4
5	Heat and Other Utilities			64,175	64,175		64,175	221	64,396		5
6	Maintenance	29,670	19,386	3,138	52,194		52,194	2,780	54,974		6
7	Other (specify):* Home Office Benefits							438	438		7
8	<b>TOTAL General Services</b>	231,392	122,534	69,833	423,759		423,759	(2,252)	421,507		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			776	776		776		776		9
10	Nursing and Medical Records	615,732	184,506	1,235	801,473		801,473	3,952	805,425		10
10a	Therapy	27,590	3,307	118,643	149,540		149,540	363	149,903		10a
11	Activities	26,074	786	578	27,438		27,438		27,438		11
12	Social Services	25,152	654		25,806		25,806		25,806		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Office Benefits							1,222	1,222		15
16	<b>TOTAL Health Care and Programs</b>	694,548	189,253	121,232	1,005,033		1,005,033	5,537	1,010,570		16
	<b>C. General Administration</b>										
17	Administrative	74,576		107,000	181,576		181,576	(37,376)	144,200		17
18	Directors Fees										18
19	Professional Services			11,279	11,279		11,279	6,643	17,922		19
20	Dues, Fees, Subscriptions & Promotions			6,614	6,614		6,614	2,038	8,652		20
21	Clerical & General Office Expenses		7,437	10,062	17,499		17,499	18,004	35,503		21
22	Employee Benefits & Payroll Taxes			134,461	134,461		134,461	6,789	141,250		22
23	Inservice Training & Education							140	140		23
24	Travel and Seminar			35	35		35	4,205	4,240		24
25	Other Admin. Staff Transportation			2,358	2,358		2,358	1,537	3,895		25
26	Insurance-Prop.Liab.Malpractice			17,045	17,045		17,045	828	17,873		26
27	Other (specify):* Home Office Benefits							3,069	3,069		27
28	<b>TOTAL General Administration</b>	74,576	7,437	288,854	370,867		370,867	5,877	376,744		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,000,516	319,224	479,919	1,799,659		1,799,659	9,162	1,808,821		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

Facility Name & ID Number Effingham Rehabilitation & Health Care Center #0047159 Report Period Beginning: 01/01/06 Ending: 12/31/06

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			45,119	45,119		45,119	4,131	49,250			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			71,469	71,469		71,469	13,995	85,464			32
33	Real Estate Taxes			17,656	17,656		17,656	296	17,952			33
34	Rent-Facility & Grounds							487	487			34
35	Rent-Equipment & Vehicles			10,845	10,845		10,845	255	11,100			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			145,089	145,089		145,089	19,164	164,253			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			33,945	33,945		33,945		33,945			42
43	Other (specify):* <b>Nonallowable Cost</b>			85,711	85,711		85,711	(85,711)				43
44	<b>TOTAL Special Cost Centers</b>			119,656	119,656		119,656	(85,711)	33,945			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,000,516	319,224	744,664	2,064,404		2,064,404	(57,385)	2,007,019			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

Facility Name & ID Number Effingham Rehabilitation & Health Care Center # 0047159 Report Period Beginning: 01/01/06 Ending: 12/31/06

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(3,665)	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	(151)	30		9
10	Interest and Other Investment Income	(2,921)			10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(123)	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	(428)	43		18
19	Entertainment				19
20	Contributions	(30)	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	(69,086)	43		24
25	Fund Raising, Advertising and Promotional	(6,494)	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 <u>See Schedule 5A</u>	(10,943)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (93,841)</b>		<b>\$</b>	<b>30</b>

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)	36,456		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ 36,456</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (57,385)</b>		<b>37</b>

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		x	\$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>		<b>47</b>

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' COMPILATION REPORT

ID# 0047159  
 Report Period Beginning: 01/01/06  
 Ending: 12/31/06

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Nonallowable marketing events	\$ (696)	43	1
2	Labs - Part A	(4,649)	43	2
3	X-Rays - Part A	(831)	43	3
4	Offset Vending Machine expense	(288)	43	4
5	Offset Vending Machine revenue	(861)	43	5
6	Offset Dues & Subscriptions	(400)	43	6
7	Offset meal revenue	(2,042)	2	7
8	Offset transportation revenue	(107)	25	8
9	Offset miscellaneous revenue	(432)	43	9
10	Nonallowable Home Office Architect Fees	(431)	19	10
11	Unreconciled Real Estate Tax Expenses	(206)	33	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	<b>Total</b>	(10,943)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Effingham Rehabilitation &amp; Health Care Center

# 0047159

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 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)	
	<b>A. General Services</b>													
1	Dietary	0	1,093	34,633	0	0	0	0	0	0	0	0	35,726	1
2	Food Purchase	(2,042)	54	34,633	0	0	0	0	0	0	0	0	32,645	2
3	Housekeeping	0	48	34,633	0	0	0	0	0	0	0	0	34,681	3
4	Laundry	0	0	34,633	0	0	0	0	0	0	0	0	34,633	4
5	Heat and Other Utilities	0	203	34,633	19	0	0	0	0	0	0	0	34,855	5
6	Maintenance	0	2,781	34,633	0	0	0	0	0	0	0	0	37,414	6
7	Other (specify):*	0	438	34,633	0	0	0	0	0	0	0	0	35,071	7
8	<b>TOTAL General Services</b>	<b>(2,042)</b>	<b>4,617</b>	<b>242,431</b>	<b>19</b>	<b>0</b>	<b>245,025</b>	<b>8</b>						
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	34,633	0	0	0	0	0	0	0	0	34,633	9
10	Nursing and Medical Records	0	3,953	34,633	0	0	0	0	0	0	0	0	38,586	10
10a	Therapy	0	362	0	0	0	0	0	0	0	0	0	362	10a
11	Activities	0	0	34,633	58,850	0	0	0	0	0	0	0	93,483	11
12	Social Services	0	0	34,633	0	0	0	0	0	0	0	0	34,633	12
13	CNA Training	0	0	34,633	0	0	0	0	0	0	0	0	34,633	13
14	Program Transportation	0	0	34,633	0	0	0	0	0	0	0	0	34,633	14
15	Other (specify):*	0	1,222	34,633	0	0	0	0	0	0	0	0	35,855	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>5,537</b>	<b>242,431</b>	<b>58,850</b>	<b>0</b>	<b>306,818</b>	<b>16</b>						
	<b>C. General Administration</b>													
17	Administrative	0	(96,226)	34,633	0	0	0	0	0	0	0	0	(61,593)	17
18	Directors Fees	0	0	34,633	0	0	0	0	0	0	0	0	34,633	18
19	Professional Services	(431)	4,719	34,633	2,354	0	0	0	0	0	0	0	41,275	19
20	Fees, Subscriptions & Promotions	0	462	34,633	1,976	0	0	0	0	0	0	0	37,071	20
21	Clerical & General Office Expenses	0	0	34,633	1,647	0	0	0	0	0	0	0	36,280	21
22	Employee Benefits & Payroll Taxes	0	0	34,633	2,806	0	0	0	0	0	0	0	37,439	22
23	Inservice Training & Education	0	0	34,633	0	0	0	0	0	0	0	0	34,633	23
24	Travel and Seminar	0	0	34,633	0	0	0	0	0	0	0	0	34,633	24
25	Other Admin. Staff Transportation	(107)	0	34,633	525	0	0	0	0	0	0	0	35,051	25
26	Insurance-Prop.Liab.Malpractice	0	0	34,633	0	0	0	0	0	0	0	0	34,633	26
27	Other (specify):*	0	0	34,633	0	0	0	0	0	0	0	0	34,633	27
28	<b>TOTAL General Administration</b>	<b>(538)</b>	<b>(91,045)</b>	<b>380,963</b>	<b>9,308</b>	<b>0</b>	<b>298,688</b>	<b>28</b>						
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(2,580)</b>	<b>(80,891)</b>	<b>865,825</b>	<b>68,177</b>	<b>0</b>	<b>850,531</b>	<b>29</b>						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Effingham Rehabilitation & Health Care Center # 0047159 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	(151)	0	34,633	0	0	0	0	0	0	0	0	34,482	30
31	Amortization of Pre-Op. & Org.	0	0	34,633	0	0	0	0	0	0	0	0	34,633	31
32	Interest	0	0	34,633	14,537	0	0	0	0	0	0	0	49,170	32
33	Real Estate Taxes	(206)	0	34,633	0	0	0	0	0	0	0	0	34,427	33
34	Rent-Facility & Grounds	0	0	34,633	0	0	0	0	0	0	0	0	34,633	34
35	Rent-Equipment & Vehicles	0	0	34,633	0	0	0	0	0	0	0	0	34,633	35
36	Other (specify):*	0	0	34,633	0	0	0	0	0	0	0	0	34,633	36
37	<b>TOTAL Ownership</b>	<b>(357)</b>	<b>0</b>	<b>242,431</b>	<b>14,537</b>	<b>0</b>	<b>256,611</b>	<b>37</b>						
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	34,633	0	0	0	0	0	0	0	0	34,633	38
39	Ancillary Service Centers	0	0	34,633	0	0	0	0	0	0	0	0	34,633	39
40	Barber and Beauty Shops	0	0	34,633	0	0	0	0	0	0	0	0	34,633	40
41	Coffee and Gift Shops	0	0	34,633	0	0	0	0	0	0	0	0	34,633	41
42	Provider Participation Fee	0	0	34,633	0	0	0	0	0	0	0	0	34,633	42
43	Other (specify):*	(87,983)	0	34,633	0	0	0	0	0	0	0	0	(53,350)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(87,983)</b>	<b>0</b>	<b>207,798</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>119,815</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(90,920)</b>	<b>(80,891)</b>	<b>1,316,054</b>	<b>82,714</b>	<b>0</b>	<b>1,226,957</b>	<b>45</b>						

Facility Name & ID Number Effingham Rehabilitation & Health Care Center

# 0047159

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

**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%	\$ 1,093	\$ 1,093	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	54	54	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	48	48	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%			4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	203	203	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	2,781	2,781	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	438	438	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	3,953	3,953	8
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	362	362	9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,222	1,222	10
11	V	17 Administrative	107,000	Petersen Health Care, Inc.	100.00%	10,774	(96,226)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	4,719	4,719	12
13	V	20 Due, Fees, Su bs & Promos		Petersen Health Care, Inc.	100.00%	462	462	13
14	Total		\$ 107,000			\$ 26,109	\$ * (80,891)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Effingham Rehabilitation & Health Care Center

# 0047159

Report Period Beginning: 01/01/06

Ending: 12/31/06

**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	21 Clerical & General Office Expenses	\$	Petersen Health Care, Inc.	100.00%	\$ 17,368	\$ 17,368	1
2	V	22 Employee Benefits		Petersen Health Care, Inc.	100.00%			2
3	V	23 Inservice Training		Petersen Health Care, Inc.	100.00%	140	140	3
4	V	24 Travel & Seminar		Petersen Health Care, Inc.	100.00%	4,205	4,205	4
5	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	1,119	1,119	5
6	V	26 Insurance-Prop, Liab & Malpractice		Petersen Health Care, Inc.	100.00%	828	828	6
7	V	27 Other		Petersen Health Care, Inc.	100.00%	3,069	3,069	7
8	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	4,282	4,282	8
9	V	32 Interest		Petersen Health Care, Inc.	100.00%	2,379	2,379	9
10	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	501	501	10
11	V	34 Rent - Facility & Grounds		Petersen Health Care, Inc.	100.00%	487	487	11
12	V	35 Rent - Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	255	255	12
13	V							13
14	Total		\$			\$ 34,633	\$ * 34,633	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Effingham Rehabilitation & Health Care Center

# 0047159

Report Period Beginning: 01/01/06

Ending: 12/31/06

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$	\$
16	V	2 Food		Petersen Health Care, Inc.	100.00%		
17	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%		
18	V	5 Utilities		Petersen Health Care, Inc.	100.00%	19	19
19	V	6 Maintenance		Petersen Health Care, Inc.	100.00%		
20	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%		
21	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%		
22	V	11 Activities		Petersen Health Care, Inc.	100.00%	58,850	58,850
23	V	17 Administrative		Petersen Health Care, Inc.	100.00%		
24	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	2,354	2,354
25	V	20 Due, Fees, Su bs & Promos		Petersen Health Care, Inc.	100.00%	1,976	1,976
26	V	21 Clerical & General Office		Petersen Health Care, Inc.	100.00%	1,647	1,647
27	V	22 Employee Benefits		Petersen Health Care, Inc.	100.00%	2,806	2,806
28	V	25 Other Admin. Staff Transport		Petersen Health Care, Inc.	100.00%	525	525
29	V	26 Insurance-Prop.Liab.Malpractice		Petersen Health Care, Inc.	100.00%		
30	V	27 Mgmt Allocation of Benefits		Petersen Health Care, Inc.	100.00%		
31	V	30 Depreciation		Petersen Health Care, Inc.	100.00%		
32	V	32 Interest		Petersen Health Care, Inc.	100.00%	14,537	14,537
33	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%		
34	V	34 Rent - Facility & Grounds		Petersen Health Care, Inc.	100.00%		
35	V	35 Rent - Equipment & Vehicles		Petersen Health Care, Inc.	100.00%		
36	V						
37	V						
38	V						
39	Total		\$			\$ 82,714	\$ * 82,714

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

Facility Name & ID Number Effingham Rehabilitation & Health Care Ce # 0047159 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	70.00	See Schedule 7A	0.67	1.35	Salary	\$ 10,774	L17,C7	1
2	Jifi C. Jacob	Owner	Administrative	10.00	See Schedule 7B	11	21.01	Salary	17,227	L17,C7	2
3	Cindy S. White	Owner	Administrative	10.00	See Schedule 7B	11	21.01	Salary	19,870	L17,C7	3
4	Jacque Whitley	Owner	Administrative	10.00	See Schedule 7B	11	21.01	Salary	21,752	L17,C7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 69,623		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Effingham Rehabilitation & Health Care Center # 0047159 Report Period Beginning: 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	15,373	\$ 1,093	1
2	2	Food	Patient Days	1,141,463	56	3,989	0	15,373	54	2
3	3	Housekeeping	Patient Days	1,141,463	56	3,589	0	15,373	48	3
4	4	Laundry	Patient Days	1,141,463	56	0	0	15,373	0	4
5	5	Utilities	Patient Days	1,141,463	56	15,054	0	15,373	203	5
6	6	Maintenance	Patient Days	1,141,463	56	206,416	110,513	15,373	2,780	6
7	7	Mgmt. Allocation of Benefits	Patient Days	1,141,463	56	32,526	0	15,373	438	7
8	10	Nursing and Medical Records	Patient Days	1,141,463	56	293,462	289,197	15,373	3,952	8
9	10A	Therapy	Patient Days	1,141,463	56	26,945	0	15,373	363	9
10	15	Mgmt. Allocation of Benefits	Patient Days	1,141,463	56	90,724	0	15,373	1,222	10
11	17	Administrative	Patient Days	1,141,463	56	800,000	800,000	15,373	10,774	11
12	19	Professional Services	Patient Days	1,141,463	56	350,362	0	15,373	4,719	12
13	20	Due, Fees, Su bs & Promos	Patient Days	1,141,463	56	34,325	0	15,373	462	13
14	21	Clerical & General Office	Patient Days	1,141,463	56	1,289,623	954,322	15,373	17,368	14
15	23	Inservice Training & Education	Patient Days	1,141,463	56	10,426	0	15,373	140	15
16	24	Travel and Seminar	Patient Days	1,141,463	56	312,259	0	15,373	4,205	16
17	25	Other Admin. Staff Transport	Patient Days	1,141,463	56	83,062	0	15,373	1,119	17
18	26	Insurance-Prop.Liab.Malpractice	Patient Days	1,141,463	56	61,457	0	15,373	828	18
19	27	Mgmt Allocation of Benefits	Patient Days	1,141,463	56	227,912	0	15,373	3,069	19
20	30	Depreciation	Patient Days	1,141,463	56	317,964	0	15,373	4,282	20
21	32	Interest	Patient Days	1,141,463	56	176,614	0	15,373	2,379	21
22	33	Real Estate Taxes	Patient Days	1,141,463	56	37,279	0	15,373	502	22
23	34	Rent - Facility & Grounds	Patient Days	1,141,463	56	36,133	0	15,373	487	23
24	35	Rent - Equipment & Vehicles	Patient Days	1,141,463	56	18,933	0	15,373	255	24
25										25
26	TOTALS					\$ 4,510,233	\$ 2,234,999		\$ 60,742	26

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Effingham Rehabilitation & Health Care Center # 0047159 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	73,177	5	\$	\$	15,373	\$	1
2	2	Food	Patient Days	73,177	5			15,373		2
3	3	Housekeeping	Patient Days	73,177	5			15,373		3
4	4	Laundry	Patient Days	73,177	5			15,373		4
5	5	Utilities	Patient Days	73,177	5	85		15,373	18	5
6	6	Maintenance	Patient Days	73,177	5			15,373		6
7	7	Mgmt. Allocation of Benefits	Patient Days	73,177	5			15,373		7
8	10	Nursing and Medical Records	Patient Days	73,177	5			15,373		8
9	10A	Therapy	Patient Days	73,177	5			15,373		9
10	15	Mgmt. Allocation of Benefits	Patient Days	73,177	5			15,373		10
11	17	Administrative	Patient Days	73,177	5	280,132	280,132	15,373	58,850	11
12	19	Professional Services	Patient Days	73,177	5	11,209		15,373	2,355	12
13	20	Due, Fees, Su bs & Promos	Patient Days	73,177	5	9,408		15,373	1,976	13
14	21	Clerical & General Office	Patient Days	73,177	5	7,841		15,373	1,647	14
15	22	Employee Benefits	Patient Days	73,177	5	13,355		15,373	2,806	15
16	24	Travel and Seminar	Patient Days	73,177	5			15,373		16
17	25	Other Admin. Staff Transport	Patient Days	73,177	5	2,500		15,373	525	17
18	26	Insurance-Prop.Liab.Malpractice	Patient Days	73,177	5			15,373		18
19	27	Mgmt Allocation of Benefits	Patient Days	73,177	5			15,373		19
20	30	Depreciation	Patient Days	73,177	5			15,373		20
21	32	Interest	Patient Days	73,177	5	69,197		15,373	14,537	21
22	33	Real Estate Taxes	Patient Days	73,177	5			15,373		22
23	34	Rent - Facility & Grounds	Patient Days	73,177	5			15,373		23
24	35	Rent - Equipment & Vehicles	Patient Days	73,177	5			15,373		24
25	TOTALS					\$ 393,727	\$ 280,132		\$ 82,714	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Effingham Rehabilitation & Health Care Cen # 0047159 Report Period Beginning: 01/01/06 Ending: 12/31/06

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

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

1	Name of Lender	2		3	4	5	6		8	9	10						
		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			
<b>A. Directly Facility Related</b>																	
<b>Long-Term</b>																	
1	F&M Bank of Galesburg		X	Mortgage	\$6,884.00	05/06/05	\$ 848,620	\$ 815,522	05/06/08	0.0748	\$ 63,969	1					
2	Robertson Healthcare		X	Second Mortgage	\$540.00	06/01/05	80,000	53,923	05/01/07	0.0800	6,480	2					
3												3					
4									Amortization of Loan costs		1,020	4					
5									Allocated from Home Office		16,916	5					
<b>Working Capital</b>																	
6									Offset Interest Income		(2,921)	6					
7												7					
8												8					
9	<b>TOTAL Facility Related</b>				\$7,424.00		\$ 928,620	\$ 869,445			\$ 85,464	9					
<b>B. Non-Facility Related*</b>																	
10												10					
11												11					
12												12					
13												13					
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14					
15	<b>TOTALS (line 9+line14)</b>						\$ 928,620	\$ 869,445			\$ 85,464	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.)



**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,

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

FACILITY NAME Effingham Rehabilitation & Health Care Cente COUNTY EFFINGHAM

FACILITY IDPH LICENSE NUMBER 0047159

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

TELEPHONE (309) 691-8113 FAX #: (309) 691-8622

**A. Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2005 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2005

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>01-14-09-200-00580</u>	<u>Nursing Home</u>	\$ <u>27,375.22</u>	\$ <u>27,375.22</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>27,375.22</u>	\$ <u>27,375.22</u>

**B. Real Estate Tax Cost Allocation:**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct 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 hom (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 200 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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Effingham Rehabilitation & Health Care Center

# 0047159 Report Period Beginning:

01/01/06 Ending:

12/31/06

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 21,644 B. General Construction Type: Exterior Brick Frame \_\_\_\_\_ Number of Stories 1

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's 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).

None

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

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

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

**XI. OWNERSHIP COSTS:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident Care</u>	<u>176,400</u>	<u>2005</u>	<u>\$ 50,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>176,400</b>		<b>\$ 50,000</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Effingham Rehabilitation & Health Care Center

# 0047159

Report Period Beginning:

01/01/06

Ending:

12/31/06

**XI. OWNERSHIP COSTS (continued)**

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	62		2005	1998	\$ 718,400	\$	30	\$ 23,947	\$ 23,947	\$ 39,911	4
5											5
6	Allocation			2006	9,169			401	401	401	6
7	From Home										7
8	Office										8
	<b>Improvement Type**</b>										
9											9
10	Building Booked					23,947			(23,947)		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	2006 Home Office Allocation - Land Improvements				530			49	49	49	30
31	2006 Home Office Allocation - Leasehold Improvements				15			1	1	1	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

Facility Name & ID Number Effingham Rehabilitation & Health Care Center

# 0047159

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	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)	\$ 728,114	\$ 23,947		\$ 24,398	\$ 451	\$ 40,362	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Effingham Rehabilitation & Health Care Center # 0047159 Report Period Beginning: 01/01/06 Ending: 12/31/06

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 209,074	\$ 21,172	\$ 20,779	\$ (393)	10	\$ 34,175	71
72	Current Year Purchases	2,928		242	242	6	242	72
73	Fully Depreciated Assets							73
74	Allocation from Home Office			3,831	3,831			74
75	TOTALS	\$ 212,002	\$ 21,172	\$ 24,852	\$ 3,680		\$ 34,417	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	N/A			\$	\$	\$	\$		\$	76
77										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)	\$ 990,116	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 45,119	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 49,250	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 4,131	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 74,779	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Effingham Rehabilitation & Health Care Center # 0047159 Report Period Beginning: 01/01/06 Ending: 12/31/06

**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		Allocation from Home Office			487			5
6								6
7	<b>TOTAL</b>				\$ 487			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending                      Annual Rent

12. \_\_\_\_\_ /2007                      \$ \_\_\_\_\_

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

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

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 \_\_\_\_\_.

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: \$ 11,100

Description: Copier 2772, Dishwasher 30, Laundry Equip 1050, Nursing Equip 6993, Home Office 255

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Effingham Rehabilitation & Health Care Center # 0047159 Report Period Beginning: 01/01/06 Ending: 12/31/06

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A - 1&3	484 hrs	\$ 12,291	690	\$ 55,101		1,174	\$ 67,392	1
2	Licensed Speech and Language Development Therapist	10A - 1&3	1 hrs	32	67	5,783		68	5,815	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A - 1,2,&3	579 hrs	15,267	746	57,759	3,307	1,325	76,333	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	<b>TOTAL</b>			\$ 27,590	1,503	\$ 118,643	\$ 3,307	2,567	\$ 149,540	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Effingham Rehabilitation & Health Care Center # 0047159 Report Period Beginning: 01/01/06 Ending: 12/31/06

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/06 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 500	\$ 500	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>None</u> )	390,141	390,141	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	7,845	7,845	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 398,486	\$ 398,486	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	50,000	50,000	13
14	Buildings, at Historical Cost	718,400	728,114	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	212,002	212,002	16
17	Accumulated Depreciation (book methods)	(70,539)	(74,779)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Loan Cost</u>	1,367	1,367	23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 911,230	\$ 916,704	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 1,309,716	\$ 1,315,190	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 367,949	\$ 367,949	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	62,825	62,825	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	27,375	27,375	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	10,880	10,880	35
<b>Other Current Liabilities(specify):</b>				
36	<u>Accrued Expenses</u>	9,246	9,246	36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 478,275	\$ 478,275	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable	869,445	869,445	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 869,445	\$ 869,445	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 1,347,720	\$ 1,347,720	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ (38,004)	\$ (32,530)	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 1,309,716	\$ 1,315,190	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 120,247	1
2	Restatements (describe):		2
3	Post Cost Report Audit Adjustment (See note on Page 18A)	(5,818)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 114,429	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(152,429)	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) <b>Rounding</b>	(4)	15
16	Other (describe)		16
17	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (152,433)	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ (38,004)	24 *

Operating Entity Only

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Effingham Rehabilitation & Health Care Center # 0047159 Report Period Beginning: 01/01/06 Ending: 12/31/06

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

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

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

1

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 1,354,678	1
2	Discounts and Allowances for all Levels	52,148	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 1,406,826	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	287,117	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 287,117	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,042	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	130,038	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	6,759	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 138,839	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	2,921	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 2,921	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Misc \$433, Transportation \$107	540	28
28a	Vending \$861, Medicare Bad Debt Reimb \$74,871	75,732	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 76,272	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 1,911,975	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	423,759	31
32	Health Care	1,005,033	32
33	General Administration	370,867	33
	<b>B. Capital Expense</b>		
34	Ownership	145,089	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	85,711	35
36	Provider Participation Fee	33,945	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,064,404	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(152,429)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (152,429)	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.  
This entity is a cash basis taxpayer.

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

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

Facility Name & ID Number Effingham Rehabilitation & Health Care Center

# 0047159

Report Period Beginning:

01/01/06

Ending:

12/31/06

**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,139	1,139	\$ 27,856	\$ 24.46	1
2	Assistant Director of Nursing		0			2
3	Registered Nurses	4,373	4,533	96,168	21.22	3
4	Licensed Practical Nurses	9,002	9,533	174,123	18.27	4
5	CNAs & Orderlies	29,452	30,797	280,279	9.10	5
6	CNA Trainees					6
7	Licensed Therapist	520	520	12,928	24.86	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,957	2,061	25,926	12.58	9
10	Activity Assistants	8	8	148	19.74	10
11	Social Service Workers	2,096	2,096	25,152	12.00	11
12	Dietician					12
13	Food Service Supervisor	672	672	7,551	11.24	13
14	Head Cook			0		14
15	Cook Helpers/Assistants	10,732	11,126	91,885	8.26	15
16	Dishwashers					16
17	Maintenance Workers	3,259	3,387	29,670	8.76	17
18	Housekeepers	7,358	7,616	77,423	10.17	18
19	Laundry	2,424	2,491	24,863	9.98	19
20	Administrator	2,521	2,601	74,576	28.67	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					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 Ca <a href="#">See Sch 20A</a>	2,609	2,625	51,969	19.80	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	78,121	81,204	\$ 1,000,516 *	\$ 12.32	34

**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	48	\$ 2,520	1, 3	35
36	Medical Director	2 Visits	776	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,235	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)	48	\$ 4,531		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

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

\*\* See instructions.

Effingham Rehabilitation & Health Care Center  
Facility # 0047159  
January 1, 2006 - December 31, 2006

Schedule 20A

XVIII. A. Staffing and Salary Costs - Line 32: Other Healthcare Costs

<u>Description</u>	<u>Hours Worked</u>	<u>Hours Paid</u>	<u>Salary or Wages</u>	<u>Ave. Hrly. Wage</u>
Care Plan Corrdinator	2,080	2,080	37,192	17.88
Restorative	2	2	115	51.05
Occupational Therapist	468	484	12,291	25.42
Speech Therapist	1	1	32	42.62
Therapists	33	33	1,649	50.74
Therapy Aides	26	26	690	26.54
	<u>2,609</u>	<u>2,625</u>	<u>51,969</u>	<u>19.80</u>

Facility Name & ID Number Effingham Rehabilitation & Health Care Center

# 0047159

Report Period Beginning: 01/01/06

Ending: 12/31/06

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Kimberly Welton	Administrator	0	\$ 24,993	Workers' Compensation Insurance	\$ 12,792	IDPH License Fee	\$ 1,621	
Jane Owens	Administrator	0	27,083	Unemployment Compensation Insurance	29,398	Advertising: Employee Recruitment	2,643	
Lola White	Administrator	0	22,500	FICA Taxes	72,143	Health Care Worker Background Check (Indicate # of checks performed <u>168</u> )	1,680	
				Employee Health Insurance	16,605	Patient Background Checks	0	
				Employee Meals	3,983	Miscellaneous Dues & Subscriptions	670	
				Illinois Municipal Retirement Fund (IMRF)*		Allocated from Home Office	2,038	
				Employee Retirement	270			
				Employee Relations	6,059	Less: Public Relations Expense	( )	
						Non-allowable advertising	( )	
						Yellow page advertising	( )	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 74,576	TOTAL (agree to Schedule V, line 22, col.8)		\$ 141,250	TOTAL (agree to Sch. V, line 20, col. 8)	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Management Fee (Adjusted on Page 6 & 6A)			\$ 107,000	N/A			Out-of-State Travel	\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 107,000				In-State Travel	
C. Professional Services							Seminar Expense	35
Vendor/Payee	Type		Amount				Allocated from Home Office	4,205
Altschuler, Melvoim & Glasser LLP	Accounting		\$ 8,450				Entertainment Expense	( )
LTC Solutions, Inc.	Computer Services		2,640				(agree to Sch. V, line 24, col. 8)	
Consolidated Communications	Computer Services		189				TOTAL	\$ 4,240
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 11,279	TOTAL		\$		

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

\*\*See instructions.

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Effingham Rehabilitation &amp; Health Care Center

# 0047159

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? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 2,410 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. \$ 33,945  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 3,983 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,042
- (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? No  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
g. Does the facility transport residents to and from day training? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.

**SEE ACCOUNTANTS' COMPILATION REPORT**