

		FOR BHF USE					

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

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

<p>I. IDPH Facility ID Number: <u>0046706</u></p> <p>Facility Name: <u>El Paso Health Care Center</u></p> <p>Address: <u>850 East 2nd Street</u> <u>El Paso</u> <u>61738</u> <small>Number City Zip Code</small></p> <p>County: <u>Woodford</u></p> <p>Telephone Number: <u>(309) 527-2700</u> Fax # <u>(309) 527-2725</u></p> <p>HFS ID Number: <u>20-1032291001</u></p> <p>Date of Initial License for Current Owners: <u>10/20/2004</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%; border: none;"><input checked="" type="checkbox"/> PROPRIETARY</td> <td style="width:33%; border: none;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Charitable Corp.</td> <td style="border: none;"><input type="checkbox"/> Individual</td> <td style="border: none;"><input type="checkbox"/> State</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"><input type="checkbox"/> Partnership</td> <td style="border: none;"><input type="checkbox"/> County</td> </tr> <tr> <td style="border: none;">IRS Exemption Code _____</td> <td style="border: none;"><input type="checkbox"/> Corporation</td> <td style="border: none;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input checked="" type="checkbox"/> Limited Liability Co.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Other _____</td> <td style="border: none;"></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Christine A. Hanover</u> Telephone Number: <u>(312) 634-4581</u> Please send copies of desk review and audit adjustments to address on this page.</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	IRS Exemption Code _____	<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>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</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 style="width:100%; border: none;"> <tr> <td style="width:20%; border: none; vertical-align: top;">Officer or Administrator of Provider</td> <td style="border: none;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="border: none; vertical-align: top;">Paid Preparer</td> <td style="border: none;">(Type or Print Name) _____</td> </tr> <tr> <td style="border: none; vertical-align: top;">Paid Preparer</td> <td style="border: none;">(Title) _____</td> </tr> <tr> <td style="border: none; vertical-align: top;">Paid Preparer</td> <td style="border: none;">(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____</td> </tr> <tr> <td style="border: none; vertical-align: top;">Paid Preparer</td> <td style="border: none;">(Print Name and Title) _____</td> </tr> <tr> <td style="border: none; vertical-align: top;">Paid Preparer</td> <td style="border: none;">(Firm Name & Address) <u>McGladrey & Pullen, LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u></td> </tr> <tr> <td style="border: none; vertical-align: top;">Paid Preparer</td> <td style="border: none;">(Telephone) <u>(312) 384-6000</u> Fax # (312) 634-5518</td> </tr> </table> <p align="center">MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____	Paid Preparer	(Type or Print Name) _____	Paid Preparer	(Title) _____	Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____	Paid Preparer	(Print Name and Title) _____	Paid Preparer	(Firm Name & Address) <u>McGladrey & Pullen, LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u>	Paid Preparer	(Telephone) <u>(312) 384-6000</u> Fax # (312) 634-5518
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number El Paso Health Care Center

0046706 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	<u>123</u>	Skilled (SNF)	<u>123</u>	<u>44,895</u>	<u>1</u>
2		Skilled Pediatric (SNF/PED)			<u>2</u>
3		Intermediate (ICF)			<u>3</u>
4		Intermediate/DD			<u>4</u>
5		Sheltered Care (SC)			<u>5</u>
6		ICF/DD 16 or Less			<u>6</u>
7	<u>123</u>	TOTALS	<u>123</u>	<u>44,895</u>	<u>7</u>

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>37,137</u>	<u>2,570</u>	<u>2,792</u>	<u>42,499</u>	<u>8</u>
9	SNF/PED					<u>9</u>
10	ICF					<u>10</u>
11	ICF/DD					<u>11</u>
12	SC					<u>12</u>
13	DD 16 OR LESS					<u>13</u>
14	TOTALS	<u>37,137</u>	<u>2,570</u>	<u>2,792</u>	<u>42,499</u>	<u>14</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.66%

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 10/20/2004

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

YES Date 10/20/2004 NO

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

YES NO If YES, enter number of beds certified 123 and days of care provided 537

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

El Paso Health Care Center

0046706

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	170,106	18,420	4,020	192,546		192,546	3,022	195,568		1
2	Food Purchase		189,506		189,506		189,506	(5,876)	183,630		2
3	Housekeeping	112,747	22,897		135,644		135,644	134	135,778		3
4	Laundry	41,879	10,125		52,004		52,004		52,004		4
5	Heat and Other Utilities			136,289	136,289		136,289	560	136,849		5
6	Maintenance	36,472	47,255	8,378	92,105		92,105	7,685	99,790		6
7	Other (specify):* Home Office Benefits							1,211	1,211		7
8	TOTAL General Services	361,204	288,203	148,687	798,094		798,094	6,736	804,830		8
	B. Health Care and Programs										
9	Medical Director			9,500	9,500		9,500		9,500		9
10	Nursing and Medical Records	1,022,440	138,790	1,342	1,162,572		1,162,572	10,926	1,173,498		10
10a	Therapy			70,658	70,658		70,658	1,003	71,661		10a
11	Activities	57,788	984	13,591	72,363		72,363		72,363		11
12	Social Services	129,407	992		130,399		130,399	(47,125)	83,274		12
13	CNA Training										13
14	Program Transportation	17,959			17,959		17,959		17,959		14
15	Other (specify):* Home Office Benefits							3,378	3,378		15
16	TOTAL Health Care and Programs	1,227,594	140,766	95,091	1,463,451		1,463,451	(31,818)	1,431,633		16
	C. General Administration										
17	Administrative	63,942		4,000	67,942		67,942	25,786	93,728		17
18	Directors Fees										18
19	Professional Services			15,790	15,790		15,790	11,783	27,573		19
20	Dues, Fees, Subscriptions & Promotions			5,633	5,633		5,633	1,278	6,911		20
21	Clerical & General Office Expenses	28,607	7,488	50,264	86,359		86,359	45,759	132,118		21
22	Employee Benefits & Payroll Taxes			359,332	359,332		359,332	3,988	363,320		22
23	Inservice Training & Education							388	388		23
24	Travel and Seminar							11,626	11,626		24
25	Other Admin. Staff Transportation			9,049	9,049		9,049	3,093	12,142		25
26	Insurance-Prop.Liab.Malpractice			40,764	40,764		40,764	2,288	43,052		26
27	Other (specify):* Home Office Benefits							8,486	8,486		27
28	TOTAL General Administration	92,549	7,488	484,832	584,869		584,869	114,475	699,344		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,681,347	436,457	728,610	2,846,414		2,846,414	89,393	2,935,807		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 El Paso Health Care Center

#0046706

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	
	D. Ownership											
30	Depreciation			78,113	78,113		78,113	(352)	77,761			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			309,701	309,701		309,701	(8,539)	301,162			32
33	Real Estate Taxes			12,000	12,000		12,000	1,388	13,388			33
34	Rent-Facility & Grounds							1,345	1,345			34
35	Rent-Equipment & Vehicles			8,793	8,793		8,793	705	9,498			35
36	Other (specify):*											36
37	TOTAL Ownership			408,607	408,607		408,607	(5,453)	403,154			37
	Ancillary Expense											
	E. Special Cost Centers											
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			68,192	68,192		68,192		68,192			42
43	Other (specify):* Nonallowable Cost			25,189	25,189		25,189	(25,189)				43
44	TOTAL Special Cost Centers			93,381	93,381		93,381	(25,189)	68,192			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	1,681,347	436,457	1,230,598	3,348,402		3,348,402	58,751	3,407,153			45

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

See Accountants' Compilation Report

Facility Name & ID Number El Paso Health Care Center

0046706

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	(696)	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	(12,190)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,537)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(13,097)	43		24
25	Fund Raising, Advertising and Promotional	(2,509)	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	(75,145)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (105,174)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	163,925		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 163,925		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 58,751		37

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

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

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

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' COMPILATION REPORT

El Paso Health Care Center

ID# 0046706

Report Period Beginning: 01/01/06

Ending: 12/31/06

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Nonallowable marketing events	\$ (6,352)	43	1
2	Labs - Part A	(721)	43	2
3	Marketing Supplies	(277)	43	3
4	Misc Income	(2,257)	21	4
5	Interest Income	(15,115)	32	5
6	Offset meal revenue	(2,037)	2	6
7	Market Salaries	(47,125)	12	7
8	Nonallowable home office architect exp	(943)	19	8
9	Architect Expense (No Support)	(319)	19	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
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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	(75,145)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number El Paso Health Care Center

0046706

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)	
	A. General Services													
1	Dietary	0	3,022	0	0	0	0	0	0	0	0	0	3,022	1
2	Food Purchase	(2,037)	149	0	0	0	0	0	0	0	0	0	(1,888)	2
3	Housekeeping	0	134	0	0	0	0	0	0	0	0	0	134	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	560	0	0	0	0	0	0	0	0	0	560	5
6	Maintenance	0	7,685	0	0	0	0	0	0	0	0	0	7,685	6
7	Other (specify):*	0	1,211	0	0	0	0	0	0	0	0	0	1,211	7
8	TOTAL General Services	(2,037)	12,761	0	0	0	0	0	0	0	0	0	10,725	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	10,926	0	0	0	0	0	0	0	0	0	10,926	10
10a	Therapy	0	1,003	0	0	0	0	0	0	0	0	0	1,003	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	(47,125)	0	0	0	0	0	0	0	0	0	0	(47,125)	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	3,378	0	0	0	0	0	0	0	0	0	3,378	15
16	TOTAL Health Care and Programs	(47,125)	15,307	0	0	0	0	0	0	0	0	0	(31,818)	16
	C. General Administration													
17	Administrative	0	25,786	0	0	0	0	0	0	0	0	0	25,786	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,262)	13,045	0	0	0	0	0	0	0	0	0	11,783	19
20	Fees, Subscriptions & Promotions	0	1,278	0	0	0	0	0	0	0	0	0	1,278	20
21	Clerical & General Office Expenses	(2,257)	0	48,015	0	0	0	0	0	0	0	0	45,759	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	388	0	0	0	0	0	0	0	0	388	23
24	Travel and Seminar	0	0	11,626	0	0	0	0	0	0	0	0	11,626	24
25	Other Admin. Staff Transportation	0	0	3,093	0	0	0	0	0	0	0	0	3,093	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,288	0	0	0	0	0	0	0	0	2,288	26
27	Other (specify):*	0	0	8,486	0	0	0	0	0	0	0	0	8,486	27
28	TOTAL General Administration	(3,519)	40,109	73,896	0	110,487	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(52,680)	68,177	73,896	0	89,393	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number El Paso Health Care Center # 0046706 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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(12,190)	0	11,838	0	0	0	0	0	0	0	0	(352)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(15,115)	0	6,576	0	0	0	0	0	0	0	0	(8,539)	32
33	Real Estate Taxes	0	0	1,388	0	0	0	0	0	0	0	0	1,388	33
34	Rent-Facility & Grounds	0	0	1,345	0	0	0	0	0	0	0	0	1,345	34
35	Rent-Equipment & Vehicles	0	0	705	0	0	0	0	0	0	0	0	705	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(27,305)	0	21,852	0	(5,453)	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):*	(25,189)	0	0	0	0	0	0	0	0	0	0	(25,189)	43
44	TOTAL Special Cost Centers	(25,189)	0	0	0	0	0	0	0	0	0	0	(25,189)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(105,174)	68,177	95,748	0	58,751	45							

Facility Name & ID Number El Paso Health Care Center # 0046706 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		
	V	1 Dietary		Petersen Health Care, Inc.	100.00%	\$ 3,022	\$ 3,022	1
	V	2 Food		Petersen Health Care, Inc.	100.00%	149	149	2
	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	134	134	3
	V	4 Laundry		Petersen Health Care, Inc.	100.00%	0		4
	V	5 Utilities		Petersen Health Care, Inc.	100.00%	560	560	5
	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	7,685	7,685	6
	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,211	1,211	7
	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	10,926	10,926	8
	V	10A Therapy		Petersen Health Care, Inc.	100.00%	1,003	1,003	9
	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	3,378	3,378	10
	V	17 Administrative	4,000	Petersen Health Care, Inc.	100.00%	29,786	25,786	11
	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	13,045	13,045	12
	V	20 Due, Fees, Su bs & Promos		Petersen Health Care, Inc.	100.00%	1,278	1,278	13
14	Total		\$ 4,000			\$ 72,177	\$ * 68,177	14

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

Facility Name & ID Number El Paso Health Care Center # 0046706 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	21 Clerical & General Office	\$	Petersen Health Care, Inc.	100.00%	\$ 48,015	\$ 48,015
16	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	388	388
17	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	11,626	11,626
18	V	25 Other Admin. Staff Transport		Petersen Health Care, Inc.	100.00%	3,093	3,093
19	V	26 Insurance-Prop.Liab.Malpractice		Petersen Health Care, Inc.	100.00%	2,288	2,288
20	V	27 Mgmt Allocation of Benefits		Petersen Health Care, Inc.	100.00%	8,486	8,486
21	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	11,838	11,838
22	V	32 Interest		Petersen Health Care, Inc.	100.00%	6,576	6,576
23	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	1,388	1,388
24	V	34 Rent - Facility & Grounds		Petersen Health Care, Inc.	100.00%	1,345	1,345
25	V	35 Rent - Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	705	705
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 95,748	\$ * 95,748

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

Facility Name & ID Number El Paso Health Care Center # 0046706 Report Period Beginning: 01/01/06 Ending: 12/31/06

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Petersen	President	Administrative	100.00	See Schedule 7A	1.86	3.72	Salary	\$ 29,784	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	\$ 29,784		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 El Paso Health Care Center# 0046706 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	\$ 42,499	\$ 3,022	1
2	2	Food	Patient Days	1,141,463	56	3,989	42,499	149	2
3	3	Housekeeping	Patient Days	1,141,463	56	3,589	42,499	134	3
4	4	Laundry	Patient Days	1,141,463	56	0	42,499	0	4
5	5	Utilities	Patient Days	1,141,463	56	15,054	42,499	560	5
6	6	Maintenance	Patient Days	1,141,463	56	206,416	110,513	7,685	6
7	7	Mgmt. Allocation of Benefits	Patient Days	1,141,463	56	32,526	42,499	1,211	7
8	10	Nursing and Medical Records	Patient Days	1,141,463	56	293,462	289,197	10,926	8
9	10A	Therapy	Patient Days	1,141,463	56	26,945	42,499	1,003	9
10	15	Mgmt. Allocation of Benefits	Patient Days	1,141,463	56	90,724	42,499	3,378	10
11	17	Administrative	Patient Days	1,141,463	56	800,000	800,000	29,786	11
12	19	Professional Services	Patient Days	1,141,463	56	350,361	42,499	13,045	12
13	20	Due, Fees, Su bs & Promos	Patient Days	1,141,463	56	34,325	42,499	1,278	13
14	21	Clerical & General Office	Patient Days	1,141,463	56	1,289,623	954,322	48,015	14
15	23	Inservice Training & Education	Patient Days	1,141,463	56	10,426	42,499	388	15
16	24	Travel and Seminar	Patient Days	1,141,463	56	312,259	42,499	11,626	16
17	25	Other Admin. Staff Transport	Patient Days	1,141,463	56	83,062	42,499	3,093	17
18	26	Insurance-Prop.Liab.Malpractice	Patient Days	1,141,463	56	61,457	42,499	2,288	18
19	27	Mgmt Allocation of Benefits	Patient Days	1,141,463	56	227,912	42,499	8,486	19
20	30	Depreciation	Patient Days	1,141,463	56	317,964	42,499	11,838	20
21	32	Interest	Patient Days	1,141,463	56	176,614	42,499	6,576	21
22	33	Real Estate Taxes	Patient Days	1,141,463	56	37,282	42,499	1,388	22
23	34	Rent - Facility & Grounds	Patient Days	1,141,463	56	36,133	42,499	1,345	23
24	35	Rent - Equipment & Vehicles	Patient Days	1,141,463	56	18,933	42,499	705	24
25	TOTALS				\$ 4,510,235	\$ 2,234,999		\$ 167,925	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number El Paso Health Care Center # 0046706 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			
A. Directly Facility Related																	
Long-Term																	
1	Associated Bank		X	Mortgage	\$36,061.00	10/20/04	\$ 3,680,000	\$ 3,562,094	01/05/09	0.0830	\$ 309,701	1					
2												2					
3												3					
4												4					
5												5					
Working Capital																	
6												6					
7												7					
8												8					
9	TOTAL Facility Related				\$36,061.00		\$ 3,680,000	\$ 3,562,094			\$ 301,162	9					
B. Non-Facility Related*																	
10												10					
11												11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$	14					
15	TOTALS (line 9+line14)						\$ 3,680,000	\$ 3,562,094			\$ 301,162	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.)

Facility Name & ID Number El Paso Health Care Center

0046706 Report Period Beginning: 01/01/06 Ending: 12/31/06

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																							
1. Real Estate Tax accrual used on 2005 report.		\$	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	\$	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.)		\$	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.		\$	7																				
<p>Real Estate Tax History:</p> <table border="1"> <tr> <td>Real Estate Tax Bill for Calendar Year:</td> <td>2001</td> <td>_____</td> <td>8</td> </tr> <tr> <td></td> <td>2002</td> <td>_____</td> <td>9</td> </tr> <tr> <td></td> <td>2003</td> <td>_____</td> <td>10</td> </tr> <tr> <td></td> <td>2004</td> <td>N/A</td> <td>11</td> </tr> <tr> <td></td> <td>2005</td> <td>N/A</td> <td>12</td> </tr> </table> <p>Real estate tax accrual based on \$1,000 a month.</p>				Real Estate Tax Bill for Calendar Year:	2001	_____	8		2002	_____	9		2003	_____	10		2004	N/A	11		2005	N/A	12
Real Estate Tax Bill for Calendar Year:	2001	_____	8																				
	2002	_____	9																				
	2003	_____	10																				
	2004	N/A	11																				
	2005	N/A	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,

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME El Paso Health Care Center COUNTY Woodford

FACILITY IDPH LICENSE NUMBER 0046706

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 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>16-04-302-017</u>	<u>Nursing Home</u>	\$ <u> </u>	\$ <u> </u>
2. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
TOTALS		\$ <u> </u>	\$ <u> </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 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 El Paso Health Care Center

0046706

Report Period Beginning:

01/01/06

Ending:

12/31/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,000 B. General Construction Type: Exterior Brick & Block 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).

N/A

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident Care</u>	<u>28,000</u>	<u>2004</u>	<u>\$ 50,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	28,000		\$ 50,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number El Paso Health Care Center

0046706

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	123		2004	1974	\$ 934,850	\$	35	\$ 26,710	\$ 26,710	\$ 57,872	4
5											5
6	Allocation			2006	25,347			1,109	1,109	1,109	6
7	From Home										7
8	Office										8
	Improvement Type**										
9	Sidewalks			2006	7,230		15	241	241	241	9
10	Windows			2006	7,500		25	150	150	150	10
11											11
12											12
13											13
14											14
15											15
16											16
17	Land Improvement Booked in GL					603			(603)		17
18	Building Booked in GL					37,457			(37,457)		18
19	Building Improvement Booked in GL					63			(63)		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	Home office allocation 2006 - Land Improvements			2006	1,465			136	136	136	34
35	Home office allocation 2006 - Building Improvements			2006	41			3	3	3	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 El Paso Health Care Center

0046706

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)		\$ 976,433	\$ 38,122		\$ 28,349	\$ (9,773)	\$ 59,511	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number El Paso Health Care Center # 0046706 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	\$ 267,497	\$ 39,991	\$ 38,213	\$ (1,778)	7	\$ 70,234	71
72	Current Year Purchases	6,085		609	609	5	609	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			10,590	10,590			74
75	TOTALS	\$ 273,582	\$ 39,991	\$ 49,412	\$ 9,421		\$ 70,843	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)	\$ 1,300,015	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 78,113	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 77,761	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (352)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 130,354	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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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			Home office allocation		1,345			5
6								6
7	TOTAL				\$ 1,345			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.

N/A

N/A

9. Option to Buy: YES NO Terms: N/A *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 9,498

Description: Nursing Equip 6671, Dishwasher 875, Copy Machine 1247, Home Office Allo 705

(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					19
20					20
21	TOTAL		\$	\$	21

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number El Paso Health Care Center # 0046706 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>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A, 3	hrs	\$	599	\$ 47,774	\$	599	\$ 47,774	1
2	Licensed Speech and Language Development Therapist	10A, 3	hrs		18	1,490		18	1,490	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A, 3	hrs		276	21,394		276	21,394	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$	893	\$ 70,658	\$	893	\$ 70,658	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 El Paso Health Care Center

0046706

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*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 3,203,263	\$ 3,203,263	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>None</u>)	530,330	530,330	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	6,177	6,177	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Employee Advances</u>	715	715	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,740,485	\$ 3,740,485	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	57,230	50,000	13
14	Buildings, at Historical Cost	942,350	976,433	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	273,582	273,582	16
17	Accumulated Depreciation (book methods)	(164,666)	(130,354)	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 (spe <u>Loan Cost</u>	25,418	25,418	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,133,914	\$ 1,195,079	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,874,399	\$ 4,935,564	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 218,784	\$ 218,784	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	107,676	107,676	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,897	1,897	31
32	Accrued Real Estate Taxes(Sch.IX-B)	23,000	23,000	32
33	Accrued Interest Payable	21,289	21,289	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
36	Other Current Liabilities(specify): <u>Accrued Expenses</u>	25,423	25,423	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 398,069	\$ 398,069	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	3,562,094	3,562,094	40
41	Bonds Payable			41
42	Deferred Compensation			42
43	Other Long-Term Liabilities(specify):			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,562,094	\$ 3,562,094	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,960,163	\$ 3,960,163	46
47	TOTAL EQUITY (page 18, line 24)	\$ 914,236	\$ 975,401	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,874,399	\$ 4,935,564	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 517,183	1
2	Restatements (describe):		2
3	Post Cost Report Adjustment - Dividend posting error	160,061	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 677,244	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	338,992	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	(102,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Rounding		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 236,992	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)	\$ 914,236	24 *

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number El Paso Health Care Center# 0046706Report Period Beginning: 01/01/06Ending: 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	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,512,127	1
2	Discounts and Allowances for all Levels	(8,903)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,503,224	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	115,658	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 115,658	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,037	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	46,923	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	2,180	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 51,140	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	15,115	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 15,115	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Income (Offset on Pg 5A)	2,257	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,257	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,687,394	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	798,094	31
32	Health Care	1,463,451	32
33	General Administration	584,869	33
	B. Capital Expense		
34	Ownership	408,607	34
	C. Ancillary Expense		
35	Special Cost Centers	25,189	35
36	Provider Participation Fee	68,192	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,348,402	40
41	Income before Income Taxes (line 30 minus line 40)**	338,992	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 338,992	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 El Paso Health Care Center

0046706

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	2,080	2,080	\$ 57,416	\$ 27.60	1
2	Assistant Director of Nursing	963	994	23,854	24.00	2
3	Registered Nurses	3,163	3,342	70,377	21.06	3
4	Licensed Practical Nurses	15,845	16,402	349,329	21.30	4
5	CNAs & Orderlies	43,924	45,873	499,665	10.89	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	974	974	15,323	15.74	9
10	Activity Assistants	5,239	5,475	42,465	7.76	10
11	Social Service Workers	7,792	8,038	82,050	10.21	11
12	Dietician			0		12
13	Food Service Supervisor	2,064	2,064	34,864	16.89	13
14	Head Cook			0		14
15	Cook Helpers/Assistants	15,976	16,990	135,242	7.96	15
16	Dishwashers					16
17	Maintenance Workers	4,011	4,173	36,472	8.74	17
18	Housekeepers	12,020	12,234	112,747	9.22	18
19	Laundry	5,145	5,313	41,879	7.88	19
20	Administrator	2,168	2,168	63,942	29.49	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,923	3,236	28,607	8.84	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 Care Plan Coord.	913	913	21,799	23.88	32
33	Other(specify) See Sch 20A	3,395	3,540	65,316	18.45	33
34	TOTAL (lines 1 - 33)	128,594	133,809	\$ 1,681,347 *	\$ 12.57	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	80	\$ 4,020	1, 3	35
36	Medical Director	Monthly	9,500	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	80	\$ 13,520		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$ N/A		50
51	Licensed Practical Nurses			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.

El Paso Health Care Center
Facility # 0046706
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>
Marketing	2,080	2,080	47,357	22.77
Transportation	1,315	1,460	17,959	12.30
	<u>3,395</u>	<u>3,540</u>	<u>65,316</u>	<u>18.45</u>

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	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	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number El Paso Health Care Center

0046706

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. \$ 281 Line 10
- (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. \$ 68,192
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. \$ 3,988 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,037
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? Adequate records have been maintained.
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? 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