

Facility Name & ID Number Havana Health Care Center

0046086 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	20	Skilled (SNF)	20	7,300	1
2		Skilled Pediatric (SNF/PED)			2
3	78	Intermediate (ICF)	78	28,470	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	98	TOTALS	98	35,770	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			6	
		Medicaid Recipient	Private Pay	Other		Total
8	SNF			2,599	2,599	8
9	SNF/PED					9
10	ICF	18,866	6,197		25,063	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,866	6,197	2,599	27,662	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.33%

D. How many bed-hold days during this year were paid by the Department? None (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 03/01/01

J. Was the facility purchased or leased after January 1, 1978?
YES Date 03/01/01 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 20 and days of care provided 2,599

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCURAL 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 **Havana Health Care Center** # **0046086** 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
1	A. General Services										
1	Dietary	144,055	21,277	5,060	170,392		170,392	1,967	172,359		1
2	Food Purchase		177,520		177,520		177,520	89	177,609		2
3	Housekeeping	77,801	10,763		88,564		88,564	87	88,651		3
4	Laundry	43,548	10,258		53,806		53,806		53,806		4
5	Heat and Other Utilities			83,118	83,118		83,118	365	83,483		5
6	Maintenance	33,258	31,708	4,110	69,076		69,076	5,002	74,078		6
7	Other (specify):* Home Ofc. Benefits							788	788		7
8	TOTAL General Services	298,662	251,526	92,288	642,476		642,476	8,298	650,774		8
	B. Health Care and Programs										
9	Medical Director			13,900	13,900		13,900		13,900		9
10	Nursing and Medical Records	992,014	102,307	4,034	1,098,355		1,098,355	4,455	1,102,810		10
10a	Therapy	50,559	150		50,709		50,709	653	51,362		10a
11	Activities	45,590	2,253	1,885	49,728		49,728		49,728		11
12	Social Services	18,699	24		18,723		18,723		18,723		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Ofc. Benefits							2,199	2,199		15
16	TOTAL Health Care and Programs	1,106,862	104,734	19,819	1,231,415		1,231,415	7,307	1,238,722		16
	C. General Administration										
17	Administrative	62,225			62,225		62,225	19,387	81,612		17
18	Directors Fees										18
19	Professional Services			12,292	12,292		12,292	7,876	20,168		19
20	Dues, Fees, Subscriptions & Promotions			3,948	3,948		3,948	832	4,780		20
21	Clerical & General Office Expenses	27,780	7,138	5,049	39,967		39,967	29,767	69,734		21
22	Employee Benefits & Payroll Taxes			182,654	182,654		182,654		182,654		22
23	Inservice Training & Education			179	179		179	253	432		23
24	Travel and Seminar			100	100		100	286	386		24
25	Other Admin. Staff Transportation			6,347	6,347		6,347	2,013	8,360		25
26	Insurance-Prop.Liab.Malpractice			28,419	28,419		28,419	1,489	29,908		26
27	Other (specify):* Home Ofc. Benefits							5,523	5,523		27
28	TOTAL General Administration	90,005	7,138	238,988	336,131		336,131	67,426	403,557		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,495,529	363,398	351,095	2,210,022		2,210,022	83,031	2,293,053		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 Havana Health Care Center

#0046086

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	
30	D. Ownership			86,105	86,105		86,105	12,647	98,752			30
31	Depreciation											31
32	Amortization of Pre-Op. & Org.											32
33	Interest			223,186	223,186		223,186	2,633	225,819			33
34	Real Estate Taxes			78,700	78,700		78,700	882	79,582			34
35	Rent-Facility & Grounds							876	876			35
36	Rent-Equipment & Vehicles			12,624	12,624		12,624	459	13,083			36
37	Other (specify):*											37
	TOTAL Ownership			400,615	400,615		400,615	17,497	418,112			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		24,765	854	25,619		25,619		25,619			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			53,655	53,655		53,655		53,655			42
43	Other (specify):* Nonallowable Cost			81,716	81,716		81,716	(81,716)				43
44	TOTAL Special Cost Centers		24,765	136,225	160,990		160,990	(81,716)	79,274			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,495,529	388,163	887,935	2,771,627		2,771,627	18,812	2,790,439			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 Havana Health Care Center

0046086

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	(2,112)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	4,942	30		9
10	Interest and Other Investment Income	(1,647)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(963)	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	(3,600)	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	(17,951)	43		24
25	Fund Raising, Advertising and Promotional	(3,706)	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	(65,450)	Varies		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (90,487)		\$	30

BHF USE ONLY							
48		49		50		51	
						52	

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	109,299	Varies	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 109,299		36
	(sum of SUBTOTALS)			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 18,812		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Havana Health Care Center

ID# 0046086

Report Period Beginning: 01/01/06

Ending: 12/31/06

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Nonallowable marketing events	\$ (2,531)	43	1
2	Labs - Part A	(32,490)	43	2
3	X-Rays - Part A	(9,113)	43	3
4	Marketing Salaries	(8,480)	43	4
5	Marketing Supplies	(770)	43	5
6	Offset meal revenue	(8)	2	6
7	Misc Revenue - Med Sup	(2,657)	10	7
8	Misc Revenue - Office Sup	(1,485)	21	8
9	Unreconciled Real Estate Taxes	(21)	33	9
10	Offset nonallowable home office travel	(7,281)	24	10
11	Offset nonallowable home office architect fees	(614)	19	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(65,450)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Havana Health Care Center

0046086 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	1,967	0	0	0	0	0	0	0	0	0	1,967	1
2	Food Purchase	(8)	97	0	0	0	0	0	0	0	0	0	89	2
3	Housekeeping	0	87	0	0	0	0	0	0	0	0	0	87	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	365	0	0	0	0	0	0	0	0	0	365	5
6	Maintenance	0	5,002	0	0	0	0	0	0	0	0	0	5,002	6
7	Other (specify):*	0	788	0	0	0	0	0	0	0	0	0	788	7
8	TOTAL General Services	(8)	8,306	0	0	0	0	0	0	0	0	0	8,298	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	(2,657)	7,112	0	0	0	0	0	0	0	0	0	4,455	10
10a	Therapy	0	653	0	0	0	0	0	0	0	0	0	653	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	2,199	0	0	0	0	0	0	0	0	0	2,199	15
16	TOTAL Health Care and Programs	(2,657)	9,964	0	0	0	0	0	0	0	0	0	7,307	16
	C. General Administration													
17	Administrative	0	19,387	0	0	0	0	0	0	0	0	0	19,387	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(614)	8,490	0	0	0	0	0	0	0	0	0	7,876	19
20	Fees, Subscriptions & Promotions	0	832	0	0	0	0	0	0	0	0	0	832	20
21	Clerical & General Office Expenses	(1,485)	0	31,252	0	0	0	0	0	0	0	0	29,767	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	253	0	0	0	0	0	0	0	0	253	23
24	Travel and Seminar	(7,281)	0	7,567	0	0	0	0	0	0	0	0	286	24
25	Other Admin. Staff Transportation	0	0	2,013	0	0	0	0	0	0	0	0	2,013	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,489	0	0	0	0	0	0	0	0	1,489	26
27	Other (specify):*	0	0	5,523	0	0	0	0	0	0	0	0	5,523	27
28	TOTAL General Administration	(9,380)	28,709	48,097	0	67,426	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(12,045)	46,979	48,097	0	83,031	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Havana Health Care Center# 0046086

Report Period Beginning:

01/01/06 Ending:12/31/06

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	4,942	0	7,705	0	0	0	0	0	0	0	0	12,647	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,647)	0	4,280	0	0	0	0	0	0	0	0	2,633	32
33	Real Estate Taxes	(21)	0	903	0	0	0	0	0	0	0	0	882	33
34	Rent-Facility & Grounds	0	0	876	0	0	0	0	0	0	0	0	876	34
35	Rent-Equipment & Vehicles	0	0	459	0	0	0	0	0	0	0	0	459	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	3,274	0	14,223	0	17,497	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):*	(81,716)	0	0	0	0	0	0	0	0	0	0	(81,716)	43
44	TOTAL Special Cost Centers	(81,716)	0	0	0	0	0	0	0	0	0	0	(81,716)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(90,487)	46,979	62,320	0	18,812	45							

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark Petersen	100	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%	\$ 1,967	\$	1,967	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	97		97	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	87		87	3
4	V	4							4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	365		365	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	5,002		5,002	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	788		788	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	7,112		7,112	8
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	653		653	9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	2,199		2,199	10
11	V	17 Administrative		Petersen Health Care, Inc.	100.00%	19,387		19,387	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	8,490		8,490	12
13	V	20 Due, Fees, Subs & Promos		Petersen Health Care, Inc.	100.00%	832		832	13
14	Total		\$			\$ 46,979	\$ *	46,979	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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%	\$ 31,252	\$ 31,252
16	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	253	253
17	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	7,567	7,567
18	V	25 Other Admin. Staff Transport		Petersen Health Care, Inc.	100.00%	2,013	2,013
19	V	26 Insurance-Prop.Liab.Malpractice		Petersen Health Care, Inc.	100.00%	1,489	1,489
20	V	27 Mgmt Allocation of Benefits		Petersen Health Care, Inc.	100.00%	5,523	5,523
21	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	7,705	7,705
22	V	32 Interest		Petersen Health Care, Inc.	100.00%	4,280	4,280
23	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	903	903
24	V	34 Rent - Facility & Grounds		Petersen Health Care, Inc.	100.00%	876	876
25	V	35 Rent - Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	459	459
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		\$			\$ 62,320	\$ * 62,320

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

SEE ACCOUNTANTS' COMPILATION REPORT

Schedule 6A

VII Related Parties - Page 6

Related Nursing Homes

City

In-State:

Aledo Rehabilitation & Health Care Center	Aledo, IL
Arcola Health Care Center	Arcola, IL
Arrow Wood Estates of Rock Falls	Rock Falls, IL
Aspen Rehab & Health Care	Silvis, IL
Batavia Rehabilitation & Health Care Center	Batavia, IL
Bement Health Care Center	Bement, IL
Benton Rehabilitation & Health Care Center	Benton, IL
Bloomington Rehabilitation & Health Care Center	Bloomington, IL
Casey Health Care Center	Casey, IL
Cisne Rehabilitation & Health Care Center	Cisne, IL
Countryview Care Center of Macomb	Macomb, IL
Countryview Terrace	Louisville, IL
Decatur Rehabilitation & Health Care Center	Decatur, IL
Eastside Health & Rehabilitation Center	Pittsfield, IL
Eastview Terrace	Sullivan, IL
Effingham Rehabilitation & Health Care Center	Effingham, IL
El Paso Health Care Center	El Paso, IL
Elgin Rehabilitation & Health Care Center	South Elgin, IL
Enfield Rehabilitation & Health Care Center	Enfield, IL
Flora Health Care Center	Flora, IL
Fondulac Rehabilitation & Health Care Center	East Peoria, IL
Havana Health Care Center	Havana, IL
Ironwood Estates of Sandwich	Sandwich, IL
Jonesboro Rehabilitation & Health Care Center	Jonesboro, IL
Kewanee Care Home	Kewanee, IL
McLeansboro Rehabilitation & Health Care Center	McLeansboro, IL
Newman Rehabilitation & Health Care Center	Newman, IL
North Aurora Care Center	Aurora, IL
Palm Terrace of Mattoon	Mattoon, IL
Prairie Rose Health Care Center	Pana, IL
Robings Manor Nursing Home	Brighton, IL
Rock Falls Rehabilitation & Health Care Center	Rock Falls, IL
Rosciclare Rehabilitation & Health Care Center	Rosciclare, IL
Royal Oaks Care Center	Kewanee, IL
Sandwich Rehabilitation & Health Care Center	Sandwich, IL
Shelbyville Rehabilitation & Health Care Center	Shelbyville, IL
Sheldon Health Care Center	Sheldon, IL
Sugar Creek Care Center	Watseka, IL
Sullivan Health Care Center	Sullivan, IL
Sunset Manor Nursing Home	Canton, IL
Timbercreek Rehabilitation & Health Care Center	Pekin, IL
Toulon Rehabilitation & Health Care Center	Toulon, IL
Tuscola Health Care Center	Tuscola, IL
Vandalia Rehabilitation & Health Care Center	Vandalia, IL
Watsseka Rehabilitation & Health Care Center	Watsseka, IL

Out-of-State:

Meadow Lawn Nursing Center	Davenport, IA
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Related Assisted Living

Kewanee Courtyard Estates	Kewanee, IL
Kewanee Courtyard Village	Kewanee, IL
Monmouth Courtyard Estates	Monmouth, IL
Riverview Estates of Havana	Havana, IL
Simple Blessings	Casey, IL

Other Related Business Entities

Petersen Health Care, Inc.	Peoria, IL	Management/Bookkeeping
Petersen Health Care II, Inc.	Peoria, IL	Management/Bookkeeping
Petersen Enterprises	Peoria, IL	Management/Bookkeeping
Petersen Health Systems	Peoria, IL	Management/Bookkeeping
Petersen Health Operations, L.L.C.	Peoria, IL	Management/Bookkeeping
RLP Senior Villages, Inc.	Peoria, IL	Management/Bookkeeping

SEE ACCOUNTANTS' COMPILATION REPORT

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	1.21	2.42	Salary	\$ 19,386	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	\$ 19,386		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 **Havana Health Care Center**

0046086 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	27,662	\$ 1,967	1
2	2	Food	Patient Days	1,141,463	56	3,989		27,662	97	2
3	3	Housekeeping	Patient Days	1,141,463	56	3,589		27,662	87	3
4										4
5	5	Utilities	Patient Days	1,141,463	56	15,054		27,662	365	5
6	6	Maintenance	Patient Days	1,141,463	56	206,416	110,513	27,662	5,002	6
7	7	Mgmt. Allocation of Benefits	Patient Days	1,141,463	56	32,526		27,662	788	7
8	10	Nursing and Medical Records	Patient Days	1,141,463	56	293,462	289,197	27,662	7,112	8
9	10A	Therapy	Patient Days	1,141,463	56	26,945		27,662	653	9
10	15	Mgmt. Allocation of Benefits	Patient Days	1,141,463	56	90,724		27,662	2,199	10
11	17	Administrative	Patient Days	1,141,463	56	800,000	800,000	27,662	19,387	11
12	19	Professional Services	Patient Days	1,141,463	56	350,361	4,303	27,662	8,490	12
13	20	Due, Fees, Subs & Promos	Patient Days	1,141,463	56	34,325		27,662	832	13
14	21	Clerical & General Office	Patient Days	1,141,463	56	1,289,623	954,322	27,662	31,252	14
15	23	Inservice Training & Education	Patient Days	1,141,463	56	10,426		27,662	253	15
16	24	Travel and Seminar	Patient Days	1,141,463	56	312,259		27,662	7,567	16
17	25	Other Admin. Staff Transport	Patient Days	1,141,463	56	83,062		27,662	2,013	17
18	26	Insurance-Prop.Liab.Malpractice	Patient Days	1,141,463	56	61,457		27,662	1,489	18
19	27	Mgmt Allocation of Benefits	Patient Days	1,141,463	56	227,912		27,662	5,523	19
20	30	Depreciation	Patient Days	1,141,463	56	317,964		27,662	7,705	20
21	32	Interest	Patient Days	1,141,463	56	176,614		27,662	4,280	21
22	33	Real Estate Taxes	Patient Days	1,141,463	56	37,282		27,662	903	22
23	34	Rent - Facility & Grounds	Patient Days	1,141,463	56	36,133		27,662	876	23
24	35	Rent - Equipment & Vehicles	Patient Days	1,141,463	56	18,933		27,662	459	24
25	TOTALS					\$ 4,510,235	\$ 2,239,302		\$ 109,299	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	LaSalle Bank		X	Mortgage	\$3,179.00	08/31/02	\$ 2,935,484	\$ 2,750,795	08/01/07	Varies	\$ 208,583	1								
2												2								
3												3								
4							Offset Interest Income				(1,647)	4								
5							Allocated from Home Office				4,280	5								
Working Capital																				
6	LaSalle Bank		X	Line of Credit	Interest only	08/31/02	254,682		12/31/06	Varies	14,603	6								
7												7								
8												8								
9	TOTAL Facility Related				\$3,179.00		\$ 3,190,166	\$ 2,750,795			\$ 225,819	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 3,190,166	\$ 2,750,795			\$ 225,819	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, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Havana Health Care Center COUNTY Mason

FACILITY IDPH LICENSE NUMBER 0046086

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

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

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. 005-1479000	Nursing Home	\$ 71,930.37	\$ 71,930.37
2. _____	Home Office allocation	\$ _____	\$ 903.00
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>71,930.37</u>	\$ <u>72,833.37</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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

SEE ACCOUNTANTS' COMPILATION REPORT

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,208 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [X] (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? [X] (a) Own the Equipment [] (b) Rent equipment from a Related Organization. [X] (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 [X] 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:

Table with 5 columns: 1 Use, 2 Square Feet, 3 Year Acquired, 4 Cost, 5. Row 1: Facility, 418,945, 2001, \$ 200,000, 1. Row 2: 2. Row 3: TOTALS, 418,945, \$ 200,000, 3.

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	98	2001	1971	\$ 1,314,000	\$	35	\$ 37,543	\$ 37,543	\$ 206,486
5									
6	Allocation		2006	16,498			722	722	722
7	From Home								
8	Office								
Improvement Type**									
9	Roof		2001	22,650		20	1,133	1,133	6,231
10	Flooring		2001	5,890		20	295	295	1,622
11	Landscaping		2001	8,984		20	449	449	2,470
12	A/C Heating Unit		2001	2,046		20	102	102	685
13	Fencing		2002	758		20	38	38	171
14	Roofing		2002	500		20	25	25	113
15	Ceiling Tiles		2003	9,516		20	476	476	1,666
16	Doors		2004	2,305		20	115	115	288
17	Nursing Station		2004	8,100		20	405	405	1,013
18	Furnace		2004	3,382		20	169	169	423
19	Water Heater		2004	2,281		20	114	114	285
20	Concrete slab work		2005	3,919		20	196	196	294
21	Roofing		2006	2,991		20	75	75	75
22									
23	2006 Allocation from Home Office - Land Improvements		2006	961			86	86	86
24	2006 Allocation from Home Office - Building Improvements		2006	20			5	5	5
25									
26	Land Improvement Booked				560			(560)	
27	Building Booked				33,692			(33,692)	
28	Building Improvement Booked				1,328			(1,328)	
29									
30									
31									
32									
33									
34									
35									
36									

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9					
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation					
37		\$	\$		\$	\$	\$	37				
38								38				
39								39				
40								40				
41								41				
42								42				
43								43				
44								44				
45								45				
46								46				
47								47				
48								48				
49								49				
50								50				
51								51				
52								52				
53								53				
54								54				
55								55				
56								56				
57								57				
58								58				
59								59				
60								60				
61								61				
62								62				
63								63				
64								64				
65								65				
66								66				
67								67				
68								68				
69								69				
70	TOTAL (lines 4 thru 69)	\$	1,404,801	\$	35,581	\$	41,948	\$	6,367	\$	222,635	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 402,795	\$ 44,533	\$ 40,280	\$ (4,253)	7-10	\$ 250,287	71
72	Current Year Purchases	4,120		206	206	7-10	206	72
73	Fully Depreciated Assets							73
74	Allocation from Home Office			6,892	6,892			74
75	TOTALS	\$ 406,915	\$ 44,533	\$ 47,378	\$ 2,845		\$ 250,493	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Use	2001 Dodge Caravan	2001	\$ 46,577	\$ 2,682	\$ 4,659	\$ 1,977	5	\$ 46,577	76
77	Facility Use	1999 Oldsmobile	2001	12,992	748	1,300	552	5	12,992	77
78	Facility Use	2001 Chevrolet	2003	10,002	1,152	2,000	848	5	7,000	78
79	Facility Use	1997 Jeep	2004	7,333	1,408	1,467	59	5	3,666	79
80	TOTALS			\$ 76,904	\$ 5,990	\$ 9,426	\$ 3,436		\$ 70,235	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)	\$ 2,088,620	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 86,104	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 98,752	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 12,648	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 543,363	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 Havana Health Care Center

0046086

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								5
6	Home Office Allocation				876			6
7	TOTAL				\$ 876			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.	<u>/2007</u>	\$ _____
13.	<u>/2008</u>	\$ _____
14.	<u>/2009</u>	\$ _____

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: \$ 13,083 Description: Copier 3886, Nursing Equip 8738, Home Office Allo 459

(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	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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. 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			
	1	2	3	4
	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.)

1	Service	Schedule V Line & Column Reference	2 Staff		3		4 Outside Practitioner (other than consultant)		5	6	7	8
			Units of Service	Cost	Units	Cost	Supplies (Actual or) Allocated	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)			
1	Licensed Occupational Therapist	10A, 1	2080	hrs	\$ 40,464		\$	\$		2,080	\$ 40,464	1
2	Licensed Speech and Language Development Therapist	10A,1	179	hrs	5,854					179	5,854	2
3	Licensed Recreational Therapist			hrs								3
4	Licensed Physical Therapist	10A,1	125	hrs	4,241				150	125	4,391	4
5	Physician Care			visits								5
6	Dental Care			visits								6
7	Work Related Program			hrs								7
8	Habilitation			hrs								8
9	Pharmacy	39, 2		# of prescripts					18,156		18,156	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs								10
11	Academic Education			hrs								11
12	Exceptional Care Program	39,3					17	854		17	854	12
13	Other (specify): <u>Oxygen</u>	39, 2							6,609		6,609	13
14	TOTAL				\$ 50,559		17	\$ 854	\$ 24,915	2,401	\$ 76,328	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

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

	1	2	
	Operating	After Consolidation*	
A. Current Assets			
1 Cash on Hand and in Banks	\$ 1,054,998	\$ 1,054,998	1
2 Cash-Patient Deposits			2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance <u>None</u>)	531,620	531,620	3
4 Supply Inventory (priced at)			4
5 Short-Term Investments			5
6 Prepaid Insurance			6
7 Other Prepaid Expenses	10,800	10,800	7
8 Accounts Receivable (owners or related parties)			8
9 Other(specify):			9
TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,597,418	\$ 1,597,418	10
B. Long-Term Assets			
11 Long-Term Notes Receivable			11
12 Long-Term Investments			12
13 Land	208,984	200,000	13
14 Buildings, at Historical Cost	1,362,529	1,404,801	14
15 Leasehold Improvements, at Historical Cos			15
16 Equipment, at Historical Cost	499,628	483,819	16
17 Accumulated Depreciation (book methods)	(610,852)	(543,363)	17
18 Deferred Charges			18
19 Organization & Pre-Operating Costs			19
20 Accumulated Amortization - Organization & Pre-Operating Costs			20
21 Restricted Funds			21
22 Other Long-Term Assets (specify):			22
23 Other(specify): <u>Due from MBP</u>	1,010,013	1,010,013	23
TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,470,302	\$ 2,555,270	24
TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,067,720	\$ 4,152,688	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26 Accounts Payable	\$ 327,962	\$ 327,962	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits			28
29 Short-Term Notes Payable			29
30 Accrued Salaries Payable	121,756	121,756	30
31 Accrued Taxes Payable (excluding real estate taxes)	2,064	2,064	31
32 Accrued Real Estate Taxes(Sch.IX-B)	72,000	72,000	32
33 Accrued Interest Payable	14,705	14,705	33
34 Deferred Compensation			34
35 Federal and State Income Taxes			35
Other Current Liabilities(specify):			
36 <u>Other Accrued Expenses</u>	24,923	24,922	36
37			37
TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 563,410	\$ 563,409	38
D. Long-Term Liabilities			
39 Long-Term Notes Payable			39
40 Mortgage Payable	2,750,795	2,750,795	40
41 Bonds Payable			41
42 Deferred Compensation			42
Other Long-Term Liabilities(specify):			
43			43
44			44
TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,750,795	\$ 2,750,795	45
TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,314,205	\$ 3,314,204	46
47 TOTAL EQUITY (page 18, line 24)	\$ 753,515	\$ 838,484	47
TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,067,720	\$ 4,152,688	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 350,078	1
2	Restatements (describe):		2
3	Post Cost Report Audit Journal Entries	(33,091)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 316,987	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	436,532	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Rounding	(4)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 436,528	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)	\$ 753,515	24 *

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

1

Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,735,661	1
2	Discounts and Allowances for all Levels	23,396	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,759,057	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	242,194	6
7	Oxygen	675	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 242,869	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants	20,323	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	8	14
15	Telephone, Television and Radic	3,016	15
16	Rental of Facility Space		16
17	Sale of Drugs	118,059	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	59,036	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 200,442	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,647	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,647	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc. Income	1,487	28
28a	Misc Med Sup Income	2,657	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,144	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,208,159	30

2

Expenses		Amount	
A. Operating Expenses			
31	General Services	642,476	31
32	Health Care	1,231,415	32
33	General Administration	336,131	33
B. Capital Expense			
34	Ownership	400,615	34
C. Ancillary Expense			
35	Special Cost Centers	107,335	35
36	Provider Participation Fee	53,655	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,771,627	40
41	Income before Income Taxes (line 30 minus line 40)**	436,532	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 436,532	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 Havana Health Care Center

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	\$ 47,349	\$ 22.76	1
2	Assistant Director of Nursing	2,080	2,080	39,326	18.91	2
3	Registered Nurses	5,659	5,932	109,254	18.42	3
4	Licensed Practical Nurses	15,386	16,124	251,330	15.59	4
5	CNAs & Orderlies	47,314	49,721	473,523	9.52	5
6	CNA Trainees					6
7	Licensed Therapist	2,388	2,388	50,559	21.17	7
8	Rehab/Therapy Aides	1,254	1,254	35,675	28.45	8
9	Activity Director	2,080	2,080	24,168	11.62	9
10	Activity Assistants	2,880	2,921	18,383	6.29	10
11	Social Service Workers	1,641	1,690	18,699	11.06	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	26,094	12.54	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,981	14,592	117,961	8.08	15
16	Dishwashers					16
17	Maintenance Workers	2,280	2,280	33,258	14.58	17
18	Housekeepers	8,424	9,041	77,801	8.61	18
19	Laundry	4,057	4,372	43,548	9.96	19
20	Administrator	2,080	2,080	62,225	29.91	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,080	2,080	27,780	13.36	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care Plan Coord.	2,080	2,080	35,557	17.09	32
33	Other(specify) Transportation	443	443	3,039	6.86	33
34	TOTAL (lines 1 - 33)	120,269	125,319	\$ 1,495,529 *	\$ 11.93	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	97	\$ 5,060	1, 3	35
36	Medical Director	Monthly	13,900	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,000	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)	97	\$ 19,960		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.

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

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
1		\$		\$	\$	\$	\$ N/A	\$	\$	\$	\$	\$
2												
3												
4												
5												
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8												
9												
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11												
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13												
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17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Havana Health Care Center

0046086

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 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? 7-10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ N/A Line N/A
- (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
-
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 53,655
This amount is to be recorded on line 42 of Schedule V
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- SEE ACCOUNTANTS' COMPILATION REPORT**
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (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 benefit on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 8
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation. N/A
- 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? Yes
Firm Name: Ginoli & Co. The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit in progress
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.