



Facility Name & ID Number Jonesboro Rehabilitation & Health Care Center

# 0047480 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>19</u>	Skilled (SNF)	<u>19</u>	<u>6,935</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>58</u>	Intermediate (ICF)	<u>58</u>	<u>21,170</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>77</u>	TOTALS	<u>77</u>	<u>28,105</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	3 Private Pay	4 Other	4 Total	
8	SNF			<u>2,790</u>	<u>2,790</u>	8
9	SNF/PED					9
10	ICF	<u>16,945</u>	<u>4,842</u>		<u>21,787</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>16,945</u>	<u>4,842</u>	<u>2,790</u>	<u>24,577</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.45%

#REF!

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES  NO

Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES  NO

I. On what date did you start providing long term care at this location?

Date started 10/1/05

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

YES  Date 10/1/05 NO

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

YES  NO  If YES, enter number of beds certified 19 and days of care provided 2,790

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.

Facility Name & ID Number Jonesboro Rehabilitation & Health Care Cent # 0047480 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
	<b>A. General Services</b>										
1	Dietary	88,987	9,615		98,602		98,602	2,442	101,044		1
2	Food Purchase		92,349		92,349		92,349	(4,451)	87,898		2
3	Housekeeping	76,107	8,724		84,831		84,831	79	84,910		3
4	Laundry	24,808	9,197		34,005		34,005		34,005		4
5	Heat and Other Utilities			59,549	59,549		59,549	324	59,873		5
6	Maintenance	23,746	20,138	2,367	46,251		46,251	6,054	52,305		6
7	Other (specify):* <b>Home Office Benefit</b>							1,521	1,521		7
8	<b>TOTAL General Services</b>	213,648	140,023	61,916	415,587		415,587	5,969	421,556		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			8,400	8,400		8,400		8,400		9
10	Nursing and Medical Records	622,688	127,987	1,770	752,445		752,445	7,542	759,987		10
10a	Therapy			220,063	220,063		220,063	580	220,643		10a
11	Activities	26,493	1,618	4,799	32,910		32,910		32,910		11
12	Social Services	18,721	26		18,747		18,747		18,747		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <b>Home Office Benefit</b>							2,373	2,373		15
16	<b>TOTAL Health Care and Programs</b>	667,902	129,631	235,032	1,032,565		1,032,565	10,495	1,043,060		16
	<b>C. General Administration</b>										
17	Administrative	35,657		59,500	95,157		95,157	(40,817)	54,340		17
18	Directors Fees										18
19	Professional Services			3,694	3,694		3,694	10,156	13,850		19
20	Dues, Fees, Subscriptions & Promotions			4,124	4,124		4,124	1,204	5,328		20
21	Clerical & General Office Expenses	20,252	4,295	8,218	32,765		32,765	34,828	67,593		21
22	Employee Benefits & Payroll Taxes			182,753	182,753		182,753	3,246	185,999		22
23	Inservice Training & Education							224	224		23
24	Travel and Seminar							902	902		24
25	Other Admin. Staff Transportation			8,552	8,552		8,552	2,650	11,202		25
26	Insurance-Prop.Liab.Malpractice			20,044	20,044		20,044	1,385	21,429		26
27	Other (specify):* <b>Home Office Benefit</b>							6,761	6,761		27
28	<b>TOTAL General Administration</b>	55,909	4,295	286,885	347,089		347,089	20,539	367,628		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	937,459	273,949	583,833	1,795,241		1,795,241	37,003	1,832,244		29

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

#REF!

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 &amp; ID Number

Jonesboro Rehabilitation &amp; Health Care Center

#0047480

Report Period Beginning:

01/01/06

Ending:

12/31/06

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			78,249	78,249		78,249	(355)	77,894			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			128,058	128,058		128,058	20,300	148,358			32
33	Real Estate Taxes			23,600	23,600		23,600	2,428	26,028			33
34	Rent-Facility & Grounds							1,106	1,106			34
35	Rent-Equipment & Vehicles			12,376	12,376		12,376	723	13,099			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			242,283	242,283		242,283	24,202	266,485			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			5,093	5,093		5,093		5,093			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			42,158	42,158		42,158		42,158			42
43	Other (specify):* <b>Nonallowable Cost</b>			90,106	90,106		90,106	(90,106)				43
44	<b>TOTAL Special Cost Centers</b>			137,357	137,357		137,357	(90,106)	47,251			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	937,459	273,949	963,473	2,174,881		2,174,881	(28,901)	2,145,980			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.

#REF!

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				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(8,540)	30		9
10	Interest and Other Investment Income	(4,941)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(956)	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	(5,655)	43		18
19	Entertainment				19
20	Contributions	(70)	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	(70,198)	43		24
25	Fund Raising, Advertising and Promotional	(2,140)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(19,398)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (111,898)</b>		<b>\$</b>	<b>30</b>

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	82,997		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ 82,997</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (28,901)</b>		<b>37</b>

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

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

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

BHF USE ONLY						
48		49		50		51
						52

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**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark Petersen		See Attached Schedule 6A		See Attached Schedule 6A		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 1,748	\$ 1,748	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	86	86	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	77	77	3
4								4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	324	324	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	4,444	4,444	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	700	700	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	6,318	6,318	8
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	580	580	9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,953	1,953	10
11	V	17 Administrative	59,500	Petersen Health Care, Inc.	100.00%	17,224	(42,276)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	7,543	7,543	12
13	V	20 Due, Fees, Subs & Promos		Petersen Health Care, Inc.	100.00%	739	739	13
14	Total		\$ 59,500			\$ 41,736	\$ * (17,764)	14

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

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**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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
		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%	\$ 27,766	\$ 27,766	15
16	V	23	Inservice Training & Education		Petersen Health Care, Inc.	100.00%	224	224	16
17	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	6,723	6,723	17
18	V	25	Other Admin. Staff Transport		Petersen Health Care, Inc.	100.00%	1,788	1,788	18
19	V	26	Insurance-Prop.Liab.Malpractice		Petersen Health Care, Inc.	100.00%	1,323	1,323	19
20	V	27	Mgmt Allocation of Benefits		Petersen Health Care, Inc.	100.00%	4,907	4,907	20
21	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	6,846	6,846	21
22	V	32	Interest		Petersen Health Care, Inc.	100.00%	3,803	3,803	22
23	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	803	803	23
24	V	34	Rent - Facility & Grounds		Petersen Health Care, Inc.	100.00%	778	778	24
25	V	35	Rent - Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	408	408	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$				\$ 55,369	\$ * 55,369	39

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

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**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 694	\$	694	15
16	V	2 Food		Petersen Health Care, Inc.	100.00%	5		5	16
17	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	2		2	17
18									18
19									19
20	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	1,610		1,610	20
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	821		821	21
22	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	1,224		1,224	22
23									23
24	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	420		420	24
25	V	17 Administrative		Petersen Health Care, Inc.	100.00%	1,459		1,459	25
26	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	3,159		3,159	26
27	V	20 Due, Fees, Subs & Promos		Petersen Health Care, Inc.	100.00%	465		465	27
28	V	21 Clerical & General Office		Petersen Health Care, Inc.	100.00%	7,062		7,062	28
29									29
30	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	648		648	30
31	V	25 Other Admin. Staff Transport		Petersen Health Care, Inc.	100.00%	862		862	31
32	V	26 Insurance-Prop.Liab.Malpractice		Petersen Health Care, Inc.	100.00%	62		62	32
33	V	27 Mgmt Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,854		1,854	33
34	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	1,339		1,339	34
35	V	32 Interest		Petersen Health Care, Inc.	100.00%	21,438		21,438	35
36	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	1,625		1,625	36
37	V	34 Rent - Facility & Grounds		Petersen Health Care, Inc.	100.00%	328		328	37
38	V	35 Rent - Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	315		315	38
39	Total		\$			\$ 45,392	\$ *	45,392	39

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

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Facility Name & ID Number Jonesboro Rehabilitation & Health Care Ce # 0047480 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	1.08	2.15	Salary	\$ 17,224	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	\$ 17,224		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

#REF!

Facility Name & ID Number Jonesboro Rehabilitation & Health Care Center # 0047480 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	1,141,512	56	\$ 81,179	\$ 80,967	24,577	\$ 1,748	1
2	2	Food	Patient Days	1,141,512	56	3,989		24,577	86	2
3	3	Housekeeping	Patient Days	1,141,512	56	3,589		24,577	77	3
4										4
5	5	Utilities	Patient Days	1,141,512	56	15,054		24,577	324	5
6	6	Maintenance	Patient Days	1,141,512	56	206,416	110,513	24,577	4,444	6
7	7	Mgmt. Allocation of Benefits	Patient Days	1,141,512	56	32,526		24,577	700	7
8	10	Nursing and Medical Records	Patient Days	1,141,512	56	293,462	289,197	24,577	6,318	8
9	10A	Therapy	Patient Days	1,141,512	56	26,945		24,577	580	9
10	15	Mgmt. Allocation of Benefits	Patient Days	1,141,512	56	90,724		24,577	1,953	10
11	17	Administrative	Patient Days	1,141,512	56	800,000	800,000	24,577	17,224	11
12	19	Professional Services	Patient Days	1,141,512	56	350,361	4,303	24,577	7,543	12
13	20	Due, Fees, Subs & Promos	Patient Days	1,141,512	56	34,325		24,577	739	13
14	21	Clerical & General Office	Patient Days	1,141,512	56	1,289,623	954,322	24,577	27,766	14
15	23	Inservice Training & Education	Patient Days	1,141,512	56	10,426		24,577	224	15
16	24	Travel and Seminar	Patient Days	1,141,512	56	312,259		24,577	6,723	16
17	25	Other Admin. Staff Transport	Patient Days	1,141,512	56	83,062		24,577	1,788	17
18	26	Insurance-Prop.Liab.Malpractice	Patient Days	1,141,512	56	61,457		24,577	1,323	18
19	27	Mgmt Allocation of Benefits	Patient Days	1,141,512	56	227,912		24,577	4,907	19
20	30	Depreciation	Patient Days	1,141,512	56	317,964		24,577	6,846	20
21	32	Interest	Patient Days	1,141,512	56	176,614		24,577	3,803	21
22	33	Real Estate Taxes	Patient Days	1,141,512	56	37,282		24,577	803	22
23	34	Rent - Facility & Grounds	Patient Days	1,141,512	56	36,133		24,577	778	23
24	35	Rent - Equipment & Vehicles	Patient Days	1,141,512	56	18,933		24,577	408	24
25	TOTALS					\$ 4,510,235	\$ 2,239,302		\$ 97,105	25

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Facility Name & ID Number Jonesboro Rehabilitation & Health Care Center # 0047480 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	427,669	46	\$ 12,081	\$ 11,958	24,577	\$ 694	1
2	2	Food	Patient Days	427,669	46	93		24,577	5	2
3	3	Housekeeping	Patient Days	427,669	46	28		24,577	2	3
4										4
5										5
6	6	Maintenance	Patient Days	427,669	46	28,012	28,012	24,577	1,610	6
7	7	Mgmt. Allocation of Benefits	Patient Days	427,669	46	14,282		24,577	821	7
8	10	Nursing and Medical Records	Patient Days	427,669	46	21,299	20,434	24,577	1,224	8
9										9
10	15	Mgmt. Allocation of Benefits	Patient Days	427,669	46	7,301		24,577	420	10
11	17	Administrative	Patient Days	427,669	46	25,391	25,391	24,577	1,459	11
12	19	Professional Services	Patient Days	427,669	46	54,971		24,577	3,159	12
13	20	Due, Fees, Subs & Promos	Patient Days	427,669	46	8,088		24,577	465	13
14	21	Clerical & General Office	Patient Days	427,669	46	122,893	64,907	24,577	7,062	14
15										15
16	24	Travel and Seminar	Patient Days	427,669	46	11,280		24,577	648	16
17	25	Other Admin. Staff Transport	Patient Days	427,669	46	15,003		24,577	862	17
18	26	Insurance-Prop.Liab.Malpractice	Patient Days	427,669	46	1,087		24,577	62	18
19	27	Mgmt Allocation of Benefits	Patient Days	427,669	46	32,265		24,577	1,854	19
20	30	Depreciation	Patient Days	427,669	46	23,301		24,577	1,339	20
21	32	Interest	Patient Days	427,669	46	373,049		24,577	21,438	21
22	33	Real Estate Taxes	Patient Days	427,669	46	28,282		24,577	1,625	22
23	34	Rent - Facility & Grounds	Patient Days	427,669	46	5,700		24,577	328	23
24	35	Rent - Equipment & Vehicles	Patient Days	427,669	46	5,479		24,577	315	24
25	TOTALS					\$ 789,885	\$ 150,702		\$ 45,392	25

###

Facility Name & ID Number Jonesboro Rehabilitation & Health Care Cent # 0047480 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	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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	LaSalle Bank		X	Mortgage	Varies	09/30/05	\$ 1,120,000	\$ 1,103,651	09/20/10	Varies	\$ 91,011	1								
2	Ziegler Healthcare		X	Mortgage	Varies	09/30/05	210,000	209,616	09/20/10	0.1000	37,047	2								
3												3								
4							Interest Income Offset				(4,941)	4								
5							Allocated from Home Office				25,241	5								
<b>Working Capital</b>																				
6												6								
7												7								
8												8								
9	<b>TOTAL Facility Related</b>						\$ 1,330,000	\$ 1,313,267			\$ 148,358	9								
<b>B. Non-Facility Related*</b>																				
10												10								
11												11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 1,330,000	\$ 1,313,267			\$ 148,358	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.) #REF!

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

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

**B. Real Estate Taxes**

		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1.	Real Estate Tax accrual used on 2005 report.			\$	<b>23,568</b>	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		\$	<b>23,568</b>	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.)			\$	<b>23,600</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$		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. <b>Home Office Allocation</b> <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$	<b>2,428</b>	6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	<b>26,028</b>	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:						
	2001	_____	8			
	2002	_____	9			
	2003	_____	10			
	2004	_____	11			
	2005	<b>23,568</b>	12			
<b>Accrual based on prior-year tax bill</b>						
				<b>FOR BHF USE ONLY</b>		
				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.**

#REF!

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 16,690 B. General Construction Type: Exterior Masonry Frame Wood Number of Stories 1

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

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

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

N/A

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

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

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Facility</u>	<u>131,116</u>	<u>2005</u>	<u>\$ 67,500</u>	1
2					2
3	<b>TOTALS</b>	<b>131,116</b>		<b>\$ 67,500</b>	<b>3</b>

#REF!

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	
	FOR BHF USE ONLY	Year	Year	Cost	Current Book	Life	Straight Line	Adjustments	Accumulated	
	Bed* 77	Acquired 2005	Constructed 1972	\$ 1,048,000	Depreciation	in Years 25	Depreciation \$ 41,920	\$ 41,920	Depreciation \$ 53,272	
4										4
5										5
6										6
7	Home Office									7
8	Allocation	2006		14,658			641	641	641	8
	Improvement Type**									
9	Original Land		2005	15,000		5	3,000	3,000	14,351	9
10	Carpet		2006	10,358		5	1,036	1,036	1,036	10
11	Sidewalks		2006	7,886		15	263	263	263	11
12										12
13	Land Improvement Booked				1,219			(1,219)		13
14	Building Booked				41,920			(41,920)		14
15	Building Improvement Booked				1,899			(1,899)		15
16										16
17										17
18	2005 - Home Office Allocation - Land Improvements			847			79	79	79	18
19	2005 - Home Office Allocation - Building Improvements			24			2	2	2	19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

#REF!

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)	\$ 1,096,773	\$ 45,038		\$ 46,941	\$ 1,903	\$ 69,644	70

#REF!

\*\*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	\$ 207,248	\$ 33,211	\$ 22,533	\$ (10,678)	3-10	\$ 33,799	71
72	Current Year Purchases	19,150		957	957	10	957	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			7,463	7,463			74
75	TOTALS	\$ 226,398	\$ 33,211	\$ 30,953	\$ (2,258)		\$ 34,756	75

D. Vehicle Depreciation (See instructions.)\*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,390,671	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 78,249	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 77,894	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (355)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 104,400	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	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	\$	92
93			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.

#REF!

**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			1,106			6
7	TOTAL				\$ 1,106			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 \_\_\_\_\_.

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: \$ 13,099 Description: Copier \$2,873; Dishwasher \$801; Heat Gun \$15; Nursing Equipment \$8,687; HO Alloc. \$723

(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.

####

Facility Name & ID Number Jonesboro Rehabilitation & Health Care Center # 0047480 Report Period Beginning: 01/01/06 Ending: 12/31/06  
**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS** (See instructions.)

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

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

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

###

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

	Service	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	951	\$ 75,908	\$	951	\$ 75,908	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		577	49,820		577	49,820	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		1,218	94,301		1,218	94,301	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39(3)			102	5,093		102	5,093	12
13	Other (specify):									13
14	<b>TOTAL</b>			\$	2,848	\$ 225,122	\$	2,848	\$ 225,122	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.

#REF!

Facility Name & ID Number Jonesboro Rehabilitation & Health Care Center

# 0047480

Report Period Beginning: 01/01/06

Ending: 12/31/06

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/06 (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 627,179	\$ 627,179	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>None</u> )	640,794	640,794	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	4,518	4,518	8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	<b>\$ 1,272,491</b>	<b>\$ 1,272,491</b>	<b>10</b>
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	1,148,744	1,164,273	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	226,398	226,398	16
17	Accumulated Depreciation (book methods)	(95,008)	(104,400)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	<b>\$ 1,280,134</b>	<b>\$ 1,286,271</b>	<b>24</b>
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	<b>\$ 2,552,625</b>	<b>\$ 2,558,762</b>	<b>25</b>

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 297,428	\$ 297,428	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	18,428	18,428	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,629	9,629	31
32	Accrued Real Estate Taxes(Sch.IX-B)	23,600	23,600	32
33	Accrued Interest Payable	13,659	13,659	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Accrued Expenses</u>	9,428	9,427	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	<b>\$ 372,172</b>	<b>\$ 372,171</b>	<b>38</b>
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable	209,616	209,616	40
41	Bonds Payable	1,103,651	1,103,651	41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	<b>\$ 1,313,267</b>	<b>\$ 1,313,267</b>	<b>45</b>
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	<b>\$ 1,685,439</b>	<b>\$ 1,685,438</b>	<b>46</b>
47	<b>TOTAL EQUITY(page 18, line 24)</b>	<b>\$ 867,186</b>	<b>\$ 873,324</b>	<b>47</b>
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	<b>\$ 2,552,625</b>	<b>\$ 2,558,762</b>	<b>48</b>

#REF!

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 156,411	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 156,411	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	710,775	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)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 710,775	17
<b>B. Transfers (Itemize):</b>			
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)	\$ 867,186	24 *

Operating Entity Only

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

#REF!

Facility Name & ID Number Jonesboro Rehabilitation & Health Care Center # 0047480 Report Period Beginning: 01/01/06 Ending: 12/31/06

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

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

		1	
	Revenue	Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,219,163	1
2	Discounts and Allowances for all Levels	173,525	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,392,688	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	325,378	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 325,378	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants	64,102	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,296	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	91,631	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	5,445	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 162,474	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	4,941	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 4,941	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Misc Income</u>	175	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 175	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,885,656	30

		2	
	Expenses	Amount	
<b>A. Operating Expenses</b>			
31	General Services	415,587	31
32	Health Care	1,032,565	32
33	General Administration	347,089	33
<b>B. Capital Expense</b>			
34	Ownership	242,283	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	95,199	35
36	Provider Participation Fee	42,158	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,174,881	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	710,775	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 710,775	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. #REF!

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

Facility Name & ID Number Jonesboro Rehabilitation & Health Care Center

# 0047480

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	2,151	2,151	\$ 45,987	\$ 21.38	1
2	Assistant Director of Nursing	810	810	14,293	17.65	2
3	Registered Nurses	3,193	3,231	30,671	9.49	3
4	Licensed Practical Nurses	15,989	16,286	246,336	15.13	4
5	CNAs & Orderlies	37,223	38,000	285,401	7.51	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,103	2,151	15,002	6.98	9
10	Activity Assistants	2,167	2,167	11,491	5.30	10
11	Social Service Workers			18,721		11
12	Dietician					12
13	Food Service Supervisor	2,096	2,104	18,771	8.92	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,663	10,811	70,216	6.49	15
16	Dishwashers					16
17	Maintenance Workers	2,096	2,128	23,746	11.16	17
18	Housekeepers	10,279	10,628	76,107	7.16	18
19	Laundry	3,571	3,748	24,808	6.62	19
20	Administrator	2,167	2,167	35,657	16.46	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,096	2,136	20,252	9.48	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	96,601	98,516	\$ 937,459 *	\$ 9.52	34

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

\*\* See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant			35
36	Medical Director	Monthly 8,400	9,3	36
37	Medical Records Consultant			37
38	Nurse Consultant	11 546	10,3	38
39	Pharmacist Consultant	Monthly 1,224	10,3	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant	1 34	10A,3	42
43	Speech Therapy Consultant			43
44	Activity Consultant	96 4,799	11,3	44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	108 \$ 15,003		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

####



**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													
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17													
18													
19													
20	<b>TOTALS</b>		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

#REF!

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

# 0047480

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? 3-7 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 9,385 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. \$ 42,158  
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.  
**#REF!**
- (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. \$ 3,246 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,296
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Ginoli & Co The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit currently in progress
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.