

Facility Name & ID Number Kewanee Care Home

0026518 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>27</u>	Skilled (SNF)	<u>27</u>	<u>9,855</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>57</u>	Intermediate (ICF)	<u>57</u>	<u>20,805</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>84</u>	TOTALS	<u>84</u>	<u>30,660</u>	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				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			<u>4,022</u>	<u>4,022</u>	8
9	SNF/PED					9
10	ICF	<u>15,882</u>	<u>7,990</u>		<u>23,872</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>15,882</u>	<u>7,990</u>	<u>4,022</u>	<u>27,894</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.98%

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 06/01/76

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 11 and days of care provided 4,022

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	121,997	13,446		135,443		135,443	1,984	137,427		1
2	Food Purchase		124,946		124,946		124,946	(5,897)	119,049		2
3	Housekeeping	92,140	13,601		105,741		105,741	88	105,829		3
4	Laundry	40,956	8,071		49,027		49,027		49,027		4
5	Heat and Other Utilities			105,455	105,455		105,455	368	105,823		5
6	Maintenance	24,247	42,644	10,445	77,336		77,336	5,044	82,380		6
7	Other (specify):* Home ofc benefit							795	795		7
8	TOTAL General Services	279,340	202,708	115,900	597,948		597,948	2,382	600,330		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	811,856	154,383	1,862	968,101		968,101	7,516	975,617		10
10a	Therapy	141,170		831	142,001		142,001		142,001		10a
11	Activities	49,120	533	4,675	54,328		54,328	(4,675)	49,653		11
12	Social Services	5,092	1,066		6,158		6,158		6,158		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home ofc benefit							2,217	2,217		15
16	TOTAL Health Care and Programs	1,007,238	155,982	19,368	1,182,588		1,182,588	5,058	1,187,646		16
	C. General Administration										
17	Administrative	48,400			48,400		48,400	19,550	67,950		17
18	Directors Fees										18
19	Professional Services			12,750	12,750		12,750	7,943	20,693		19
20	Dues, Fees, Subscriptions & Promotions			3,611	3,611		3,611	261	3,872		20
21	Clerical & General Office Expenses	43,393	7,485	24,828	75,706		75,706	30,843	106,549		21
22	Employee Benefits & Payroll Taxes			185,766	185,766		185,766	3,832	189,598		22
23	Inservice Training & Education							255	255		23
24	Travel and Seminar			154	154		154	7,631	7,785		24
25	Other Admin. Staff Transportation			15,928	15,928		15,928	2,030	17,958		25
26	Insurance-Prop.Liab.Malpractice			38,717	38,717		38,717	1,502	40,219		26
27	Other (specify):* Home ofc benefit							5,569	5,569		27
28	TOTAL General Administration	91,793	7,485	281,754	381,032		381,032	79,416	460,448		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,378,371	366,175	417,022	2,161,568		2,161,568	86,856	2,248,424		29

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

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

Facility Name & ID Number

Kewanee Care Home

#0026518

Report Period Beginning:

01/01/06

Ending:

12/31/06

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			72,282	72,282		72,282	28,945	101,227			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			198,737	198,737		198,737	(10,867)	187,870			32
33	Real Estate Taxes			26,374	26,374		26,374	148	26,522			33
34	Rent-Facility & Grounds							883	883			34
35	Rent-Equipment & Vehicles			4,283	4,283		4,283	463	4,746			35
36	Other (specify):*											36
37	TOTAL Ownership			301,676	301,676		301,676	19,572	321,248			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		41,081		41,081		41,081		41,081			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			45,990	45,990		45,990		45,990			42
43	Other (specify):* Nonallowable Cost			82,657	82,657		82,657	(81,721)	936			43
44	TOTAL Special Cost Centers		41,081	128,647	169,728		169,728	(81,721)	88,007			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,378,371	407,256	847,345	2,632,972		2,632,972	24,707	2,657,679			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 **Kewanee Care Home**

0026518

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	(2,162)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,705)	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	21,175	30		9
10	Interest and Other Investment Income	(2,666)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,006)	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	(580)	43		18
19	Entertainment				19
20	Contributions	(2,762)	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	(23,806)	43		24
25	Fund Raising, Advertising and Promotional	(2,040)	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	(64,959)	Var.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (85,511)		\$	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)	110,218		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 110,218		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 24,707		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

Kewanee Care Home

ID# 0026518

Report Period Beginning: 01/01/06

Ending: 12/31/06

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Nonallowable marketing events	\$ (3,460)	43	1
2	Nonallowable marketing supplies	(127)	43	2
3	Labs - Part A	(36,170)	43	3
4	X-Rays - Part A	(5,060)	43	4
5	Unreconciled real estate tax	(763)	33	5
6	Vending machine expense	(5)	43	6
7	Disallowed special events	(4,675)	11	7
8	Disallowed dues	(578)	20	8
9	Nonallowable home office architect fees	(619)	19	9
10	Misc Revenue Offset - Med Supplies	(672)	27	10
11	Misc Revenue Offset - Admin	(313)	10	11
12	Mortgage interest offset	(12,517)	32	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	(64,959)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Kewanee Care Home# 0026518

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	1,984	0	0	0	0	0	0	0	0	0	1,984	1
2	Food Purchase	(2,162)	97	0	0	0	0	0	0	0	0	0	(2,065)	2
3	Housekeeping	0	88	0	0	0	0	0	0	0	0	0	88	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	368	0	0	0	0	0	0	0	0	0	368	5
6	Maintenance	0	5,044	0	0	0	0	0	0	0	0	0	5,044	6
7	Other (specify):*	0	795	0	0	0	0	0	0	0	0	0	795	7
8	TOTAL General Services	(2,162)	8,376	0	0	0	0	0	0	0	0	0	6,214	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	(313)	7,171	0	0	0	0	0	0	0	0	0	6,858	10
10a	Therapy	0	658	0	0	0	0	0	0	0	0	0	658	10a
11	Activities	(4,675)	0	0	0	0	0	0	0	0	0	0	(4,675)	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	2,217	0	0	0	0	0	0	0	0	0	2,217	15
16	TOTAL Health Care and Programs	(4,988)	10,046	0	0	0	0	0	0	0	0	0	5,058	16
	C. General Administration													
17	Administrative	0	19,550	0	0	0	0	0	0	0	0	0	19,550	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(619)	8,562	0	0	0	0	0	0	0	0	0	7,943	19
20	Fees, Subscriptions & Promotions	(578)	839	0	0	0	0	0	0	0	0	0	261	20
21	Clerical & General Office Expenses	0	0	31,515	0	0	0	0	0	0	0	0	31,515	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	255	0	0	0	0	0	0	0	0	255	23
24	Travel and Seminar	0	0	7,631	0	0	0	0	0	0	0	0	7,631	24
25	Other Admin. Staff Transportation	0	0	2,030	0	0	0	0	0	0	0	0	2,030	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,502	0	0	0	0	0	0	0	0	1,502	26
27	Other (specify):*	(672)	0	5,569	0	0	0	0	0	0	0	0	4,897	27
28	TOTAL General Administration	(1,869)	28,951	48,502	0	75,584	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(9,019)	47,373	48,502	0	86,856	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Kewanee Care Home # 0026518 Report Period Beginning: 01/01/06 Ending: 12/31/06

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	21,175	0	7,770	0	0	0	0	0	0	0	0	28,945	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(15,183)	0	4,316	0	0	0	0	0	0	0	0	(10,867)	32
33	Real Estate Taxes	(763)	0	911	0	0	0	0	0	0	0	0	148	33
34	Rent-Facility & Grounds	0	0	883	0	0	0	0	0	0	0	0	883	34
35	Rent-Equipment & Vehicles	0	0	463	0	0	0	0	0	0	0	0	463	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	5,229	0	14,343	0	19,572	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):*	(81,721)	0	0	0	0	0	0	0	0	0	0	(81,721)	43
44	TOTAL Special Cost Centers	(81,721)	0	0	0	0	0	0	0	0	0	0	(81,721)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(85,511)	47,373	62,845	0	24,707	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%	\$ 1,984	\$ 1,984	1	
2	V	2 Food		Petersen Health Care, Inc.	100.00%	97	97	2	
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	88	88	3	
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	0		4	
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	368	368	5	
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	5,044	5,044	6	
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	795	795	7	
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	7,171	7,171	8	
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	658	658	9	
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	2,217	2,217	10	
11	V	17 Administrative		Petersen Health Care, Inc.	100.00%	19,550	19,550	11	
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	8,562	8,562	12	
13	V	20 Dues, Fees, Subs, & Promos		Petersen Health Care, Inc.	100.00%	839	839	13	
14	Total		\$			\$ 47,373	\$ *	47,373	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%	\$ 31,515	\$	31,515	15
16	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	255		255	16
17	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	7,631		7,631	17
18	V	25 Other Admin. Staff Transport		Petersen Health Care, Inc.	100.00%	2,030		2,030	18
19	V	26 Insurance-Prop.Liab.Malpractice		Petersen Health Care, Inc.	100.00%	1,502		1,502	19
20	V	27 Mgmt Allocation of Benefits		Petersen Health Care, Inc.	100.00%	5,569		5,569	20
21	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	7,770		7,770	21
22	V	32 Interest		Petersen Health Care, Inc.	100.00%	4,316		4,316	22
23	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	911		911	23
24	V	34 Rent - Facility & Grounds		Petersen Health Care, Inc.	100.00%	883		883	24
25	V	35 Rent - Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	463		463	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		\$			\$ 62,845	\$ *	62,845	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Kewanee Care Home

0026518

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	1.22	2.44	Salary	\$ 19,550	17(7)	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	\$ 19,550		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 Kewanee Care Home

0026518

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	\$ 27,894	\$ 1,984	1
2	2	Food	Patient Days	1,141,463	56	3,989	27,894	97	2
3	3	Housekeeping	Patient Days	1,141,463	56	3,589	27,894	88	3
4	4	Laundry	Patient Days	1,141,463	56	0	27,894	0	4
5	5	Utilities	Patient Days	1,141,463	56	15,054	27,894	368	5
6	6	Maintenance	Patient Days	1,141,463	56	206,416	110,513	5,044	6
7	7	Mgmt. Allocation of Benefits	Patient Days	1,141,463	56	32,526	27,894	795	7
8	10	Nursing and Medical Records	Patient Days	1,141,463	56	293,462	289,197	7,171	8
9	10A	Therapy	Patient Days	1,141,463	56	26,945	27,894	658	9
10	15	Mgmt. Allocation of Benefits	Patient Days	1,141,463	56	90,724	27,894	2,217	10
11	17	Administrative	Patient Days	1,141,463	56	800,000	800,000	19,550	11
12	19	Professional Services	Patient Days	1,141,463	56	350,361	27,894	8,562	12
13	20	Due, Fees, Su bs & Promos	Patient Days	1,141,463	56	34,325	27,894	839	13
14	21	Clerical & General Office	Patient Days	1,141,463	56	1,289,623	954,322	31,515	14
15	23	Inservice Training & Education	Patient Days	1,141,463	56	10,426	27,894	255	15
16	24	Travel and Seminar	Patient Days	1,141,463	56	312,259	27,894	7,631	16
17	25	Other Admin. Staff Transport	Patient Days	1,141,463	56	83,062	27,894	2,030	17
18	26	Insurance-Prop.Liab.Malpractice	Patient Days	1,141,463	56	61,457	27,894	1,502	18
19	27	Mgmt Allocation of Benefits	Patient Days	1,141,463	56	227,912	27,894	5,569	19
20	30	Depreciation	Patient Days	1,141,463	56	317,964	27,894	7,770	20
21	32	Interest	Patient Days	1,141,463	56	176,614	27,894	4,316	21
22	33	Real Estate Taxes	Patient Days	1,141,463	56	37,282	27,894	911	22
23	34	Rent - Facility & Grounds	Patient Days	1,141,463	56	36,133	27,894	883	23
24	35	Rent - Equipment & Vehicles	Patient Days	1,141,463	56	18,933	27,894	463	24
25	TOTALS					\$ 4,510,235	\$ 2,234,999	\$ 110,218	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Kewanee Care Home

0026518

Report Period Beginning:

01/01/06

Ending:

12/31/06

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					Monthly Payment Required	Date of Note				Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO									Original	Balance			
A. Directly Facility Related																
Long-Term																
1	LaSalle Bank		X	Mortgage	Varies	08/31/02	\$ 2,276,498	\$ 2,723,961	08/31/07	Varies	179,962					
2	Community State Bank		X	Van Purchase	\$722.00	10/23/02	43,315	6,294	09/23/07	0.0850	6,258					
3											3					
4									Interest income offset		(2,666)					
5									Allocated from home office		4,316					
Working Capital																
6											6					
7											7					
8											8					
9	TOTAL Facility Related				\$722.00		\$ 2,319,813	\$ 2,730,255			\$ 187,870					
B. Non-Facility Related*																
10	Associated Bank		X	Mortgage on House	\$879.00	11/16/05	70,500	65,448	10/16/15	0.0850						
11											11					
12											12					
13											13					
14	TOTAL Non-Facility Related				\$879.00		\$ 70,500	\$ 65,448			\$					
15	TOTALS (line 9+line14)						\$ 2,390,313	\$ 2,795,703			\$ 187,870					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2005 report.		\$	19,605	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	\$	22,716	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3,111	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	22,500	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. Home office allocation			911	
TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	26,522	7

Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2001	8,888	8
	2002	9,670	9
	2003	21,080	10
	2004	22,615	11
	2005	22,716	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2005	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Kewanee Care Home COUNTY Henry

FACILITY IDPH LICENSE NUMBER 0026518

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

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

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>25-05-281-017</u>	<u>901 W. Mill St.</u>	\$ <u>100.06</u>	\$ <u>100.06</u>
2. <u>25-04-151-009</u>	<u>144 Junior Ave.</u>	\$ <u>22,540.08</u>	\$ <u>22,540.08</u>
3. <u>25-04-152-001</u>	<u>821 Dewey Ave.</u>	\$ <u>75.76</u>	\$ <u>75.76</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>22,715.90</u>	\$ <u>22,715.90</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

Facility Name & ID Number Kewanee Care Home

0026518 Report Period Beginning:

01/01/06 Ending:

12/31/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 12,548 B. General Construction Type: Exterior Brick Frame Steel Number of Stories One

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

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

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

None

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

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

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident Care</u>	<u>42,000</u>	<u>1976</u>	<u>\$ 25,000</u>	<u>1</u>
2	<u>Resident Care</u>	<u>11,250</u>	<u>1992</u>	<u>25,621</u>	<u>2</u>
3	TOTALS	53,250		\$ 50,621	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Kewanee Care Home

0026518

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	65	1976		\$ 381,128	\$	30	\$	\$	\$ 381,128	4
5	11	1998		753,696		40	18,842	18,842	162,211	5
6	8	2002		672,751		40	16,819	16,819	42,046	6
7	Allocation From		2006	16,636			728	728	728	7
8	Home Office									8
	Improvement Type**									
9	Various		1984	14,365		30	479	479	10,571	9
10	Various		1985	7,400		10			7,400	10
11	Various		1987	10,278		10-15	0	0	10,278	11
12	Various		1988	14,958		10-15	0	0	14,958	12
13	Various		1989	1,900		15			1,900	13
14	Various		1991	8,793		15	146	146	8,793	14
15	Various		1992	16,898		12			16,898	15
16	Various		1993	4,962		10			4,962	16
17	Various		1994	22,158		15	1,477	1,477	17,848	17
18	Various		1995	31,243		20	1,562	1,562	18,000	18
19	Tile Flooring		1996	1,083		20	54	54	585	19
20	Curtains Custom		1996	1,275		20	64	64	683	20
21	Emergency Light		1996	304		20	15	15	160	21
22	Fire Alarm		1996	2,099		20	105	105	1,120	22
23	Tile Flooring		1996	1,287		20	64	64	677	23
24	Boiler		1996	2,996		20	150	150	1,538	24
25	Water Heater Repair		1996	1,010		20	51	51	557	25
26	Ceiling Repairs		1996	2,117		20	106	106	1,157	26
27	Piping Repairs		1996	855		20	43	43	469	27
28	Fire Alarm		1996	1,331		20	67	67	681	28
29	Fire System		1996	1,564		20	78	78	813	29
30	Landscaping		1996	9,815		20	491	491	5,196	30
31	Landscaping		1996	1,986		20	99	99	1,023	31
32	Chrome Door Knob		1996	72		20	4	4	43	32
33	Emergency Light		1996	182		20	9	9	99	33
34	Painting		1996	672		20	34	34	368	34
35	Floor Tile		1997	8,472		20	424	424	4,169	35
36										36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Kewanee Care Home

0026518

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Storage Shed	1997	\$ 10,177	\$	20	\$ 509	\$ 509	\$ 4,793	37
38	Windows	1997	5,136		20	257	257	2,442	38
39	Ceiling Repairs	1997	8,291		20	415	415	3,873	39
40	Landscaping	1997	8,085		20	404	404	3,737	40
41	Landscaping	1997	1,298		20	65	65	601	41
42	Whirlpool	1997	9,343		20	467	467	4,242	42
43	Boiler	1997	3,000		20	150	150	1,375	43
44	Wing Additions	1997	3,700		20	185	185	1,680	44
45	Attic Piping	1997	3,318		20	166	166	1,563	45
46	Compressor	1997	809		20	40	40	363	46
47	Fire Alarm	1997	2,338		20	117	117	1,132	47
48	Code Alert Receiver	1997	1,863		20	93	93	899	48
49	New sign	1998	7,304		20	365	365	5,840	49
50	Landscaping	1998	21,500		20	1,075	1,075	9,317	50
51	Duct Work-New Wing	1999	1,494		20	75	75	562	51
52	Tiling	1999	914		20	46	46	345	52
53	Water Heater	1999	2,835		20	142	142	1,065	53
54	Water Heater	1999	3,766		20	188	188	1,410	54
55	Cubicle Partitions	1999	701		20	35	35	262	55
56	Beauty Salon	2000	943		20	47	47	306	56
57	Tile Flooring	2000	10,294		20	515	515	3,347	57
58	Lot/House Razed	2000	21,237		20	1,062	1,062	6,903	58
59	Concrete	2001	900		15	60	60	360	59
60	Landscaping	2001	1,045		15	70	70	421	60
61	Lighting	2001	3,438		39	88	88	528	61
62	Blinds/Curtains	2001	9,500		7	1,357	1,357	8,142	62
63	Landscaping	2002	24,614		15	1,641	1,641	7,384	63
64	Landscaping	2002	4,075		15	272	272	1,224	64
65	Architectural	2002	21,778		20	1,089	1,089	4,900	65
66	Carpeting	2002	2,551		20	128	128	576	66
67	Fire System	2002	4,677		20	234	234	1,053	67
68	Landscaping	2003	4,899		15	327	327	1,144	68
69	Simplex Time Clock	2004	3,198		10	320	320	800	69
70	TOTAL (lines 4 thru 69)		\$ 2,203,307	\$		\$ 53,912	\$ 53,912	\$ 799,645	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,203,307	\$		\$ 53,912	\$ 53,912	\$ 799,645	1
2	Air Conditioner	2004	2,700		10	270	270		2
3								675	3
4	Side walks	2005	2,065		15	138	138	276	4
5	Floor covering	2005	13,891		7	1,984	1,984	3,968	5
6	Flooring	2006	28,527		25	571	571	571	6
7									7
8									8
9	Land Improvement Booked			3,979			(3,979)		9
10	Building Booked			19,325			(19,325)		10
11	Building Improvement Booked			28,575			(28,575)		11
12									12
13									13
14									14
15									15
16									16
17	2006 Home Office Allocation - Land Improvements	2006	962			89	89	89	17
18	2006 Home Office Allocation - Building	2006	27			2	2	2	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	TOTAL (lines 1 thru 33)		\$ 2,251,479	\$ 51,879		\$ 56,965	\$ 5,086	\$ 805,225	34

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	\$ 304,198	\$ 16,853	\$ 29,908	\$ 13,055	7 - 10	\$ 278,942	71
72	Current Year Purchases	6,567		385	385		385	72
73	Fully Depreciated Assets	107,989						73
74	Allocation from Home Office			6,951	6,951			74
75	TOTALS	\$ 418,754	\$ 16,853	\$ 37,244	\$ 20,391		\$ 279,327	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	1997 Dodge Caravan	1998	\$ 32,369	\$ 1,775	\$	\$ (1,775)	4	\$ 32,369	76
77	Facility	2000 Town & Country	2002	35,088	1,775	7,018	5,243	5	31,581	77
78										78
79										79
80	TOTALS			\$ 67,457	\$ 3,550	\$ 7,018	\$ 3,468		\$ 63,950	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)	\$ 2,788,311	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 72,282	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 101,227	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 28,945	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,148,502	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	November 2005 - House	\$ 70,500	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 70,500	\$	\$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

	1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:			\$			3
4	Additions						4
5							5
6	Home office allocation			883			6
7	TOTAL			\$ 883			7

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

This amount was calculated by dividing the total amount to be amortized N/A
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: \$ 4,746 Description: See Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2007 \$ _____

13. _____ /2008 \$ _____

14. _____ /2009 \$ _____

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Petersen Health Care, Inc. (Kewanee)
FYE: 12/31/2006
Medicaid Cost Report Workpapers

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Copier	\$	2,440
Dishwasher		875
Laundry Equipment		73
Medical Equipment		895
Home Office Allocation		463
		<u>4,746</u>

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	2114 hrs	\$ 24,260		\$	\$	2,114	\$ 24,260	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	1865 hrs	116,910	10	831		1,875	117,741	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 prescrpts				41,081		41,081	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$ 141,170	10	\$ 831	\$ 41,081	3,989	\$ 183,082	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Kewanee Care Home**

0026518

Report Period Beginning: **01/01/06**

Ending:

12/31/06

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/06**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 4,897,704	\$ 4,897,704	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>None</u>)	630,654	630,654	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	1,055	1,055	6
7	Other Prepaid Expenses	7,496	7,496	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Employee Educ. Loans</u>	1,843	1,843	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,538,752	\$ 5,538,752	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	151,595	50,621	13
14	Buildings, at Historical Cost	2,139,715	2,251,479	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	520,486	486,211	16
17	Accumulated Depreciation (book methods)	(1,239,699)	(1,148,502)	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: <u>Non care- House</u>)	70,500	70,500	22
23	Other(specify): <u>See Schedule 17A</u>	961,141	961,141	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,603,738	\$ 2,671,450	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,142,490	\$ 8,210,202	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 417,201	\$ 417,201	26
27	Officer's Accounts Payable	6,500	6,500	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	109,130	109,130	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,838	2,838	31
32	Accrued Real Estate Taxes(Sch.IX-B)	22,500	22,500	32
33	Accrued Interest Payable	12,669	12,669	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Schedule 17A</u>	19,110	19,110	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 589,948	\$ 589,948	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,795,703	2,795,703	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,795,703	\$ 2,795,703	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,385,651	\$ 3,385,651	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,756,839	\$ 4,824,551	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 8,142,490	\$ 8,210,202	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Schedule 17A

XV Balance Sheet

B. Long-Term Assets Line 23

	Operating	After Consolidation
Other(specify):		
Security Deposit	870	870
Due from MBP	960,271	960,271
	<u>961,141</u>	<u>961,141</u>

C. Current Liabilities Line 36

Fica W/H & Empl/r Fica	4,508	4,508
Federal Withholding	5,361	5,361
State Withholding II	3,358	3,358
Wage Garnishment	1,397	1,397
Tuition Grant	0	0
Other Withholdings	959	959
401-K Withholding	4,577	4,577
Other Withholdings	(990)	(990)
Earned Income Credit	(60)	(60)
Vision/Dental W/H	4,090	4,090
	<u>23,200</u>	<u>23,200</u>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,758,956	1
2	Restatements (describe):		2
3	Post Cost Report Audit Adjustments	(24,122)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,734,834	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,022,005	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)	\$ 1,022,005	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)	\$ 4,756,839	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	\$ 2,912,208	1
2	Discounts and Allowances for all Levels	198,560	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,110,768	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	304,111	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 304,111	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,162	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	204,077	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	30,011	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 236,250	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,666	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,666	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Schedule 19A</u>	1,182	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,182	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,654,977	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	597,948	31
32	Health Care	1,182,588	32
33	General Administration	381,032	33
	B. Capital Expense		
34	Ownership	301,676	34
	C. Ancillary Expense		
35	Special Cost Centers	123,738	35
36	Provider Participation Fee	45,990	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,632,972	40
41	Income before Income Taxes (line 30 minus line 40)**	1,022,005	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,022,005	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.

Kewanee Care Home
Provider # 00026518
12/31/2005

Schedule 19 A

XVII Income Statement
E. Other Revenue (Specify)

Other Revenue

Transportation	197
Miscellaneous	985

1,182

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Kewanee Care Home

0026518

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,080	2,080	\$ 50,018	\$ 24.05	1
2	Assistant Director of Nursing	1,733	1,733	31,760	18.32	2
3	Registered Nurses	1,903	1,909	35,837	18.77	3
4	Licensed Practical Nurses	17,336	17,972	247,942	13.80	4
5	CNAs & Orderlies	43,382	44,711	423,601	9.47	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,936	2,132	29,507	13.84	9
10	Activity Assistants	1,719	1,908	14,347	7.52	10
11	Social Service Workers	364	364	5,092	14.00	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	20,941	10.07	13
14	Head Cook			0		14
15	Cook Helpers/Assistants	13,661	14,204	101,056	7.11	15
16	Dishwashers					16
17	Maintenance Workers	1,949	2,047	24,247	11.85	17
18	Housekeepers	10,203	10,644	92,140	8.66	18
19	Laundry	5,452	5,745	40,956	7.13	19
20	Administrator	1,756	1,756	48,400	27.56	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	3,655	3,716	43,393	11.68	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 C: CPC	427	427	22,698	53.20	32
33	Other(specify) <u>See Pg 20A</u>	4,566	4,598	146,435	31.85	33
34	TOTAL (lines 1 - 33)	114,203	118,025	\$ 1,378,371 *	\$ 11.68	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	12,000	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	12	1,862	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)	12	\$ 13,862		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

Petersen Health Care, Inc. (Kewanee)
Provider Number - 0026518
FYE: 12/31/2006

Schedule 20A

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

<u>Description</u>	<u>Hours Worked</u>	<u>Hours Paid</u>	<u>Salary or Wages</u>	<u>Ave. Hrly. Wage</u>
Physical therapy aide	1,666	1,666	25,708	15.43
COTA	2,105	2,114	24,260	11.48
Therapist	199	199	91,203	459.07
Transportation	596	620	5,265	8.50
	<u>4,566</u>	<u>4,598</u>	<u>146,435</u>	<u>31.85</u>

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description	Amount	Description	Amount		
<u>Brent Morgan</u>	<u>Administrator</u>	<u>0</u>	\$ <u>9,234</u>	<u>Workers' Compensation Insurance</u>	\$ <u>49,914</u>	<u>IDPH License Fee</u>	\$ _____		
<u>Nat Smith</u>	<u>Administrator</u>	<u>0</u>	<u>39,166</u>	<u>Unemployment Compensation Insurance</u>	<u>25,257</u>	<u>Advertising: Employee Recruitment</u>	<u>530</u>		
				<u>FICA Taxes</u>	<u>103,094</u>	<u>Health Care Worker Background Check</u>	<u>1,130</u>		
				<u>Employee Health Insurance</u>	<u>(7,022)</u>	(Indicate # of checks performed <u>113</u>)			
				<u>Employee Meals</u>	<u>3,832</u>	<u>Patient Background Checks</u>			
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Miscellaneous Licenses & Fees</u>	<u>1,373</u>		
				<u>Employee Pension Contribution</u>	<u>2,573</u>	<u>Miscellaneous Dues & Subscriptions</u>	<u>578</u>		
				<u>Employee Relations</u>	<u>11,950</u>	<u>Allocated from Home Office</u>	<u>839</u>		
TOTAL (agree to Schedule V, line 17, col. 1)			\$ <u>48,400</u>						
(List each licensed administrator separately.)									
B. Administrative - Other			Amount	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
<u>N/A</u>			\$ _____	<u>N/A</u>		\$ _____	<u>Out-of-State Travel</u>	\$ _____	
							<u>In-State Travel</u>		
TOTAL (agree to Schedule V, line 17, col. 3)			\$ _____	TOTAL (agree to Schedule V, line 22, col.8)			\$ <u>189,598</u>	TOTAL (agree to Sch. V, line 20, col. 8)	
(Attach a copy of any management service agreement)									\$ <u>3,872</u>
C. Professional Services			Amount						
Vendor/Payee	Type		Amount						
<u>Altschuler, Melvoin & Glasser</u>	<u>Accounting</u>		\$ <u>5,850</u>						
<u>Lindon Engineering</u>	<u>Cost Segregation</u>		<u>3,094</u>						
<u>Interiors by Jama</u>	<u>Interior Design</u>		<u>125</u>						
<u>Kewanee.com</u>	<u>Computer Services</u>		<u>387</u>						
<u>IVANS</u>	<u>Computer Services</u>		<u>141</u>						
<u>LTC Solutions, Inc.</u>	<u>Computer Services</u>		<u>2,640</u>						
<u>Network Business Solutions</u>	<u>Computer Services</u>		<u>40</u>						
<u>Insight Communications</u>	<u>Computer Services</u>		<u>420</u>						
<u>Misc. Vendors</u>	<u>Computer Services</u>		<u>53</u>						
TOTAL (agree to Schedule V, line 19, column 3)			\$ <u>12,750</u>	TOTAL			\$ _____	Seminar Expense	
(If total legal fees exceed \$5,000, attach copy of invoices.)									<u>154</u>
							<u>Allocated from Home Office</u>		<u>7,631</u>
							<u>Entertainment Expense</u>		(_____)
							TOTAL (agree to Sch. V, line 24, col. 8)		\$ <u>7,785</u>

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Petersen Health Care, Inc. (Kewanee)
Provider Number - 0026518
FYE: 12/31/2006

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Total (agree to Schedule V, line 19, column 3) 12,750

Allocated from Home Office

Other Professional Fees	8,448	
Legal	114	
Home Office Architect Fee Offset, per Sch VI	(619)	7,943

Total (agree to Schedule V, line 19, column 8) 20,693

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

(See instructions.)

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Kewanee Care Home# 0026518

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? 7 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 9,956 Line 10(2)
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 45,990
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 3,832 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,162
- (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? 0
- 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