

		FOR BHF USE					

LL1

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

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

**I. IDPH Facility ID Number:** 0047498

**Facility Name:** McLeansboro Rehabilitation & Health Care Center

**Address:** 405 West Carpenter McLeansboro 62859  
 Number City Zip Code

**County:** Hamilton

**Telephone Number:** (618) 643-3728 **Fax #** (618) 643-2330

**HFS ID Number:** 20-3224201014

**Date of Initial License for Current Owners:** 10/1/2005

**Type of Ownership:**

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code <u>          </u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other <u>          </u>
	<input type="checkbox"/> "Sub-S" Corp.	
	<input checked="" type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other <u>          </u>	

**In the event there are further questions about this report, please contact:**  
 Name: Christine A. Hanover Telephone Number: (312) 634-4581  
 Please send copies of desk review and audit adjustments to address on this page.

**II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/06 to 12/31/06 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) _____	
	(Title) _____	
Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u>	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) <u>McGladrey &amp; Pullen, LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u>	
	(Telephone) <u>(312) 384-6000</u> Fax # <u>(312) 634-5518</u>	

MAIL TO: BUREAU OF HEALTH FINANCE  
 ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES  
 201 S. Grand Avenue East  
 Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number McLeansboro Rehabilitation & Health Care Center

# 0047498 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>43</u>	Skilled (SNF)	<u>43</u>	<u>15,695</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>43</u>	TOTALS	<u>43</u>	<u>15,695</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>10,498</u>	<u>2,525</u>	<u>1,540</u>	<u>14,563</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>10,498</u>	<u>2,525</u>	<u>1,540</u>	<u>14,563</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.79%

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 10/1/2005

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

YES  Date 10/1/2005 NO

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

YES  NO  If YES, enter number of beds certified 43 and days of care provided 1,540

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 McLeansboro Rehabilitation & Health Care ( # 0047498 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	100,839	4,095		104,934		104,934	1,447	106,381		1
2	Food Purchase		63,650		63,650		63,650	(4,250)	59,400		2
3	Housekeeping	40,119	4,992		45,111		45,111	47	45,158		3
4	Laundry	29,814	9,222	424	39,460		39,460		39,460		4
5	Heat and Other Utilities			55,403	55,403		55,403	192	55,595		5
6	Maintenance	28,946	14,785	1,053	44,784		44,784	3,587	48,371		6
7	Other (specify):* <b>Home Office Benefits</b>							901	901		7
8	<b>TOTAL General Services</b>	199,718	96,744	56,880	353,342		353,342	1,924	355,266		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			5,500	5,500		5,500		5,500		9
10	Nursing and Medical Records	526,805	57,004	1,200	585,009		585,009	4,469	589,478		10
10a	Therapy			99,470	99,470		99,470	344	99,814		10a
11	Activities	22,659	1,809	2,230	26,698		26,698		26,698		11
12	Social Services	25,148	72		25,220		25,220		25,220		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <b>Home Office Benefits</b>							1,406	1,406		15
16	<b>TOTAL Health Care and Programs</b>	574,612	58,885	108,400	741,897		741,897	6,219	748,116		16
	<b>C. General Administration</b>										
17	Administrative	62,068		36,500	98,568		98,568	(25,429)	73,139		17
18	Directors Fees										18
19	Professional Services			4,261	4,261		4,261	6,341	10,602		19
20	Dues, Fees, Subscriptions & Promotions			4,023	4,023		4,023	713	4,736		20
21	Clerical & General Office Expenses	27,860	3,051	5,095	36,006		36,006	20,637	56,643		21
22	Employee Benefits & Payroll Taxes			192,760	192,760		192,760	3,632	196,392		22
23	Inservice Training & Education			170	170		170	133	303		23
24	Travel and Seminar			99	99		99	535	634		24
25	Other Admin. Staff Transportation			4,844	4,844		4,844	1,571	6,415		25
26	Insurance-Prop.Liab.Malpractice			13,721	13,721		13,721	821	14,542		26
27	Other (specify):* <b>Home Office Benefits</b>							4,007	4,007		27
28	<b>TOTAL General Administration</b>	89,928	3,051	261,473	354,452		354,452	12,961	367,413		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	864,258	158,680	426,753	1,449,691		1,449,691	21,104	1,470,795		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.

## 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			52,690	52,690		52,690	4,402	57,092			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			88,818	88,818		88,818	12,219	101,037			32
33	Real Estate Taxes			6,800	6,800		6,800	1,439	8,239			33
34	Rent-Facility & Grounds							655	655			34
35	Rent-Equipment & Vehicles			6,570	6,570		6,570	429	6,999			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			154,878	154,878		154,878	19,144	174,022			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		2,205		2,205		2,205		2,205			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			23,543	23,543		23,543		23,543			42
43	Other (specify):* <b>Nonallowable Cost</b>			51,953	51,953		51,953	(51,953)				43
44	<b>TOTAL Special Cost Centers</b>		2,205	75,496	77,701		77,701	(51,953)	25,748			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	864,258	160,885	657,127	1,682,270		1,682,270	(11,705)	1,670,565			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

**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	(672)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,004)	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	(447)	30		9
10	Interest and Other Investment Income	(2,737)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(310)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(191)	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	(39,185)	43		24
25	Fund Raising, Advertising and Promotional	(1,917)	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 Pg 5A	(11,179)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (59,642)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	47,937		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 47,937		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (11,705)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

BHF USE ONLY					
48		49		50	
				51	
					52

SEE ACCOUNTANTS' COMPILATION REPORT

McLeansboro Rehabilitation & Health Care Center

ID# 0047498

Report Period Beginning: 01/01/06

Ending: 12/31/06

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Nonallowable marketing events	\$ (1,503)	43	1
2	Labs - Part A	(4,683)	43	2
3	X-Rays - Part A	(828)	43	3
4	Marketing Supplies	(332)	43	4
5	Disallow non-allowable travel expense	(3,833)	24	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(11,179)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number McLeansboro Rehabilitation & Health Care Center# 0047498

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	1,036	0	411	0	0	0	0	0	0	0	1,447	1
2	Food Purchase	(672)	51	0	3	0	0	0	0	0	0	0	(618)	2
3	Housekeeping	0	46	0	1	0	0	0	0	0	0	0	47	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	192	0	0	0	0	0	0	0	0	0	192	5
6	Maintenance	0	2,633	0	954	0	0	0	0	0	0	0	3,587	6
7	Other (specify):*	0	415	0	486	0	0	0	0	0	0	0	901	7
8	<b>TOTAL General Services</b>	<b>(672)</b>	<b>4,373</b>	<b>0</b>	<b>1,855</b>	<b>0</b>	<b>5,556</b>	<b>8</b>						
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	3,744	0	725	0	0	0	0	0	0	0	4,469	10
10a	Therapy	0	344	0	0	0	0	0	0	0	0	0	344	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	1,157	0	249	0	0	0	0	0	0	0	1,406	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>5,245</b>	<b>0</b>	<b>974</b>	<b>0</b>	<b>6,219</b>	<b>16</b>						
	<b>C. General Administration</b>													
17	Administrative	0	(26,294)	0	865	0	0	0	0	0	0	0	(25,429)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	4,469	0	1,872	0	0	0	0	0	0	0	6,341	19
20	Fees, Subscriptions & Promotions	0	438	0	275	0	0	0	0	0	0	0	713	20
21	Clerical & General Office Expenses	0	0	16,452	4,185	0	0	0	0	0	0	0	20,637	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	133	0	0	0	0	0	0	0	0	133	23
24	Travel and Seminar	(3,833)	0	3,984	384	0	0	0	0	0	0	0	535	24
25	Other Admin. Staff Transportation	0	0	1,060	511	0	0	0	0	0	0	0	1,571	25
26	Insurance-Prop.Liab.Malpractice	0	0	784	37	0	0	0	0	0	0	0	821	26
27	Other (specify):*	0	0	2,908	1,099	0	0	0	0	0	0	0	4,007	27
28	<b>TOTAL General Administration</b>	<b>(3,833)</b>	<b>(21,387)</b>	<b>25,321</b>	<b>9,228</b>	<b>0</b>	<b>9,329</b>	<b>28</b>						
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(4,505)</b>	<b>(11,769)</b>	<b>25,321</b>	<b>12,057</b>	<b>0</b>	<b>21,104</b>	<b>29</b>						

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number McLeansboro Rehabilitation & Health Care Center # 0047498 Report Period Beginning: 01/01/06 Ending: 12/31/06

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(447)	0	4,056	793	0	0	0	0	0	0	0	4,402	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,737)	0	2,253	12,703	0	0	0	0	0	0	0	12,219	32
33	Real Estate Taxes	0	0	476	963	0	0	0	0	0	0	0	1,439	33
34	Rent-Facility & Grounds	0	0	461	194	0	0	0	0	0	0	0	655	34
35	Rent-Equipment & Vehicles	0	0	242	187	0	0	0	0	0	0	0	429	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(3,184)</b>	<b>0</b>	<b>7,488</b>	<b>14,840</b>	<b>0</b>	<b>19,144</b>	<b>37</b>						
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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):*	(51,953)	0	0	0	0	0	0	0	0	0	0	(51,953)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(51,953)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(51,953)</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(59,642)</b>	<b>(11,769)</b>	<b>32,809</b>	<b>26,897</b>	<b>0</b>	<b>(11,705)</b>	<b>45</b>						

**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:	
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)	
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 1,036	\$ 1,036	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	51	51	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	46	46	3
4	V	5 Utilities		Petersen Health Care, Inc.	100.00%	192	192	4
5	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	2,633	2,633	5
6	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	415	415	6
7	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	3,744	3,744	7
8	V	10A Therapy		Petersen Health Care, Inc.	100.00%	344	344	8
9	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,157	1,157	9
10	V	17 Administrative	36,500	Petersen Health Care, Inc.	100.00%	10,206	(26,294)	10
11	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	4,469	4,469	11
12	V	20 Due, Fees, Subs & Promos		Petersen Health Care, Inc.	100.00%	438	438	12
13	V							13
14	Total		\$ 36,500			\$ 24,731	\$ * (11,769)	14

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

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%	\$ 16,452	\$	16,452	15
16	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	133		133	16
17	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	3,984		3,984	17
18	V	25 Other Admin. Staff Transport		Petersen Health Care, Inc.	100.00%	1,060		1,060	18
19	V	26 Insurance-Prop.Liab.Malpractice		Petersen Health Care, Inc.	100.00%	784		784	19
20	V	27 Mgmt Allocation of Benefits		Petersen Health Care, Inc.	100.00%	2,908		2,908	20
21	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	4,056		4,056	21
22	V	32 Interest		Petersen Health Care, Inc.	100.00%	2,253		2,253	22
23	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	476		476	23
24	V	34 Rent-Facility & Grounds		Petersen Health Care, Inc.	100.00%	461		461	24
25	V	35 Rent - Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	242		242	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		\$			\$ 32,809	\$ *	32,809	39

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

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	<u>1</u> <u>Dietary</u>	\$	<u>Petersen Health Care, Inc.</u>	100.00%	\$ 411	\$	411	15
16	V	<u>2</u> <u>Food</u>		<u>Petersen Health Care, Inc.</u>	100.00%	3		3	16
17	V	<u>3</u> <u>Housekeeping</u>		<u>Petersen Health Care, Inc.</u>	100.00%	1		1	17
18	V	<u>6</u> <u>Maintenance</u>		<u>Petersen Health Care, Inc.</u>	100.00%	954		954	18
19	V	<u>7</u> <u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Care, Inc.</u>	100.00%	486		486	19
20	V	<u>10</u> <u>Nursing and Medical Records</u>		<u>Petersen Health Care, Inc.</u>	100.00%	725		725	20
21	V	<u>15</u> <u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Care, Inc.</u>	100.00%	249		249	21
22	V	<u>17</u> <u>Administrative</u>		<u>Petersen Health Care, Inc.</u>	100.00%	865		865	22
23	V	<u>19</u> <u>Professional Services</u>		<u>Petersen Health Care, Inc.</u>	100.00%	1,872		1,872	23
24	V	<u>20</u> <u>Due, Fees, Subs &amp; Promos</u>		<u>Petersen Health Care, Inc.</u>	100.00%	275		275	24
25	V	<u>21</u> <u>Clerical &amp; General Office</u>		<u>Petersen Health Care, Inc.</u>	100.00%	4,185		4,185	25
26	V	<u>24</u> <u>Travel and Seminar</u>		<u>Petersen Health Care, Inc.</u>	100.00%	384		384	26
27	V	<u>25</u> <u>Other Admin. Staff Transport</u>		<u>Petersen Health Care, Inc.</u>	100.00%	511		511	27
28	V	<u>26</u> <u>Insurance-Prop.Liab.Malpractice</u>		<u>Petersen Health Care, Inc.</u>	100.00%	37		37	28
29	V	<u>27</u> <u>Mgmt Allocation of Benefits</u>		<u>Petersen Health Care, Inc.</u>	100.00%	1,099		1,099	29
30	V	<u>30</u> <u>Depreciation</u>		<u>Petersen Health Care, Inc.</u>	100.00%	793		793	30
31	V	<u>32</u> <u>Interest</u>		<u>Petersen Health Care, Inc.</u>	100.00%	12,703		12,703	31
32	V	<u>33</u> <u>Real Estate Taxes</u>		<u>Petersen Health Care, Inc.</u>	100.00%	963		963	32
33	V	<u>34</u> <u>Rent - Facility &amp; Grounds</u>		<u>Petersen Health Care, Inc.</u>	100.00%	194		194	33
34	V	<u>35</u> <u>Rent - Equipment &amp; Vehicles</u>		<u>Petersen Health Care, Inc.</u>	100.00%	187		187	34
35	V								35
36	V								36
37	V								37
38	V								38
39	<b>Total</b>		\$			\$ 26,897	\$ *	26,897	39

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

Facility Name & ID Number McLeansboro Rehabilitation & Health Care # 0047498 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	0.64	1.28	Salary	\$ 10,206	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	\$ 10,206		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 McLeansboro Rehabilitation & Health Care Center # 0047498 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	56	\$ 81,179	\$ 80,967	14,563	\$ 1,036	1
2	2	Food	Patient Days	56	3,989		14,563	51	2
3	3	Housekeeping	Patient Days	56	3,589		14,563	46	3
4	5	Utilities	Patient Days	56	15,054		14,563	192	4
5	6	Maintenance	Patient Days	56	206,416	110,513	14,563	2,633	5
6	7	Mgmt. Allocation of Benefits	Patient Days	56	32,526		14,563	415	6
7	10	Nursing and Medical Records	Patient Days	56	293,462	289,197	14,563	3,744	7
8	10A	Therapy	Patient Days	56	26,945		14,563	344	8
9	15	Mgmt. Allocation of Benefits	Patient Days	56	90,724		14,563	1,157	9
10	17	Administrative	Patient Days	56	800,000	800,000	14,563	10,206	10
11	19	Professional Services	Patient Days	56	350,361	4,303	14,563	4,469	11
12	20	Due, Fees, Subs & Promos	Patient Days	56	34,325		14,563	438	12
13	21	Clerical & General Office	Patient Days	56	1,289,623	954,322	14,563	16,452	13
14	23	Inservice Training & Education	Patient Days	56	10,426		14,563	133	14
15	24	Travel and Seminar	Patient Days	56	312,259		14,563	3,984	15
16	25	Other Admin. Staff Transport	Patient Days	56	83,062		14,563	1,060	16
17	26	Insurance-Prop.Liab.Malpractice	Patient Days	56	61,457		14,563	784	17
18	27	Mgmt. Allocation of Benefits	Patient Days	56	227,912		14,563	2,908	18
19	30	Depreciation	Patient Days	56	317,964		14,563	4,056	19
20	32	Interest	Patient Days	56	176,614		14,563	2,253	20
21	33	Real Estate Taxes	Patient Days	56	37,282		14,563	476	21
22	34	Rent - Facility & Grounds	Patient Days	56	36,133		14,563	461	22
23	35	Rent - Equipment & Vehicles	Patient Days	56	18,933		14,563	242	23
24									24
25	TOTALS				\$ 4,510,235	\$ 2,239,302		\$ 57,540	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number McLeansboro Rehabilitation & Health Care Center # 0047498 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

B. Show the allocation of costs below. If necessary, please attach worksheets.

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

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	14,563	\$ 411	1
2	2	Food	Patient Days	427,669	46	93		14,563	3	2
3	3	Housekeeping	Patient Days	427,669	46	28		14,563	1	3
4	6	Maintenance	Patient Days	427,669	46	28,012	28,012	14,563	954	4
5	7	Mgmt. Allocation of Benefits	Patient Days	427,669	46	14,282		14,563	486	5
6	10	Nursing and Medical Records	Patient Days	427,669	46	21,299	20,434	14,563	725	6
7	15	Mgmt. Allocation of Benefits	Patient Days	427,669	46	7,301		14,563	249	7
8	17	Administrative	Patient Days	427,669	46	25,391	25,391	14,563	865	8
9	19	Professional Services	Patient Days	427,669	46	54,971		14,563	1,872	9
10	20	Due, Fees, Subs & Promos	Patient Days	427,669	46	8,088		14,563	275	10
11	21	Clerical & General Office	Patient Days	427,669	46	122,893	64,907	14,563	4,185	11
12	24	Travel and Seminar	Patient Days	427,669	46	11,280		14,563	384	12
13	25	Other Admin. Staff Transport	Patient Days	427,669	46	15,003		14,563	511	13
14	26	Insurance-Prop.Liab.Malpractice	Patient Days	427,669	46	1,087		14,563	37	14
15	27	Mgmt. Allocation of Benefits	Patient Days	427,669	46	32,265		14,563	1,099	15
16	30	Depreciation	Patient Days	427,669	46	23,301		14,563	793	16
17	32	Interest	Patient Days	427,669	46	373,049		14,563	12,703	17
18	33	Real Estate Taxes	Patient Days	427,669	46	28,282		14,563	963	18
19	34	Rent - Facility & Grounds	Patient Days	427,669	46	5,700		14,563	194	19
20	35	Rent - Equipment & Vehicles	Patient Days	427,669	46	5,479		14,563	187	20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 789,885	\$ 150,702		\$ 26,897	25

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

1	Name of Lender	2		3	4	5	6		7	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			
<b>A. Directly Facility Related</b>																	
<b>Long-Term</b>																	
1	LaSalle Bank		X	Mortgage	Varies	09/30/05	\$ 770,000	\$ 758,760	09/20/10	Varies	\$ 65,469	1					
2	Ziegler Healthcare		X	Mortgage	Varies	09/30/05	150,000	149,726	09/20/10	0.1000	23,349	2					
3												3					
4							Allocated from Home Office				14,956	4					
5							Offset Interest Income				(2,737)	5					
<b>Working Capital</b>																	
6												6					
7												7					
8												8					
9	<b>TOTAL Facility Related</b>						\$ 920,000	\$ 908,486			\$ 101,037	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>						\$ 920,000	\$ 908,486			\$ 101,037	15					

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

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
 (See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

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

**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.		\$	<b>6,661</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>6,661</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>6,800</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>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			<b>1,439</b>	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>8,239</b>	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2001	_____	8	
	2002	_____	9	
	2003	_____	10	
	2004	_____	11	
	2005	<b>6,660</b>	12	
<b>Tax accrual calculated based on prior year tax bills.</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.**

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 McLeansboro Rehabilitation & Health Care Center COUNTY Hamilton

FACILITY IDPH LICENSE NUMBER 0047498

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>07-154-005-00</u>	<u>Nursing Home</u>	\$ <u>6,589.08</u>	\$ <u>6,589.08</u>
2. <u>07-154-007-00</u>	<u>Nursing Home</u>	\$ <u>71.14</u>	\$ <u>71.14</u>
3. _____	<u>Home Office Building</u>	\$ _____	\$ <u>1,439.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>6,660.22</u>	\$ <u>8,099.22</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.

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 11,840 B. General Construction Type: Exterior Brick Frame Fire Resistant Number of Stories 1

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

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

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

None

---



---



---



---



---

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

1. Total Amount Incurred: 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: N/A  
 (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>Facility</u>	<u>56,628</u>	<u>2005</u>	<u>\$ 40,500</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>56,628</b>		<b>\$ 40,500</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number McLeansboro Rehabilitation & Health Care Center

# 0047498

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	73	2005	1973	\$ 727,500	\$ 29,185	25	\$ 29,100	\$ (85)	\$ 43,650	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Original Land Improvements		2005	14,000	933	15	933		1,400	9
10										10
11	Allocated from Home Office			9,201			428	428	428	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

\*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 **McLeansboro Rehabilitation & Health Care Center**

# **0047498**

Report Period Beginning:

**01/01/06**

Ending:

**12/31/06**

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9			
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation			
37		\$	\$		\$	\$	\$	37		
38								38		
39								39		
40								40		
41								41		
42								42		
43								43		
44								44		
45								45		
46								46		
47								47		
48								48		
49								49		
50								50		
51								51		
52								52		
53								53		
54								54		
55								55		
56								56		
57								57		
58								58		
59								59		
60								60		
61								61		
62								62		
63								63		
64								64		
65								65		
66								66		
67								67		
68								68		
69								69		
70	<b>TOTAL (lines 4 thru 69)</b>	\$	<b>750,701</b>	\$	<b>30,461</b>	\$	<b>343</b>	\$	<b>45,478</b>	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 144,430	\$ 21,700	\$ 21,664	\$ (36)	3-7	\$ 32,496	71
72	Current Year Purchases	11,041	872	545	(327)	5-7	545	72
73	Fully Depreciated Assets							73
74	Allocated from Home Office			4,422	4,422			74
75	TOTALS	\$ 155,471	\$ 22,572	\$ 26,631	\$ 4,059		\$ 33,041	75

D. Vehicle Depreciation (See instructions.)\*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 946,672	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 52,690	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 57,092	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 4,402	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 78,519	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		\$	92
93	N/A		93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

**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	Allocated from Home Office				655			6
7	TOTAL				\$ 655			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: N/A \*

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 6,999 Description: Copier-\$3,349; Dishwasher-\$708; Laundry Equip-\$206; Nursing Equip-\$2,736

(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.

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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.
- SEE ACCOUNTANTS' COMPILATION REPORT**

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	388	\$ 30,956	\$	388	\$ 30,956	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		50	4,313		50	4,313	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3,7)	hrs		829	64,201		829	64,201	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescripts				84		84	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <u>Oxygen</u>	39(2)					2,121		2,121	13
14	<b>TOTAL</b>			\$	1,267	\$ 99,470	\$ 2,205	1,267	\$ 101,675	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 **McLeansboro Rehabilitation & Health Care Center** # **0047498** 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	\$ 525	\$ 525	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>-0-</u> )	327,248	327,248	3
4	Supply Inventory (priced at <u>          </u> )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	6,621	6,621	7
8	Accounts Receivable (owners or related parties)	18,430	18,430	8
9	Other(specify): <u>                          </u>			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 352,824	\$ 352,824	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	40,500	40,500	13
14	Buildings, at Historical Cost	741,500	750,185	14
15	Leasehold Improvements, at Historical Cost		516	15
16	Equipment, at Historical Cost	155,471	155,471	16
17	Accumulated Depreciation (book methods)	(62,280)	(78,519)	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>                          </u>			22
23	Other(specify): <u>Security Deposits</u>	32,454	32,454	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 907,645	\$ 900,607	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,260,469	\$ 1,253,431	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 294,452	\$ 294,452	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	18,122	18,122	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,709	4,709	31
32	Accrued Real Estate Taxes(Sch.IX-B)	6,800	6,800	32
33	Accrued Interest Payable	9,480	9,480	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Payroll Withholding Liabilities</u>	8,905	8,905	36
37	<u>  </u>			37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 342,468	\$ 342,468	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable	149,726	149,726	40
41	Bonds Payable	758,760	758,760	41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<u>  </u>			43
44	<u>  </u>			44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 908,486	\$ 908,486	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,250,954	\$ 1,250,954	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 9,515	\$ 2,477	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,260,469	\$ 1,253,431	48

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>49,957</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>49,957</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(40,442)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(40,442)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>9,515</b>	<b>24</b> *

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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 1,345,020	1
2	Discounts and Allowances for all Levels	56,293	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 1,401,313	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	130,897	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 130,897	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants	39,184	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	672	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	49,966	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	15,963	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 105,785	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	2,737	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 2,737	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Miscellaneous</u>	1,096	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 1,096	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 1,641,828	30

2

Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	353,342	31
32	Health Care	741,897	32
33	General Administration	354,452	33
<b>B. Capital Expense</b>			
34	Ownership	154,878	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	54,158	35
36	Provider Participation Fee	23,543	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 1,682,270	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(40,442)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (40,442)	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 facility is a cash basis taxpayer.

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

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

Facility Name & ID Number McLeansboro Rehabilitation & Health Care Center

# 0047498

Report Period Beginning: 01/01/06

Ending: 12/31/06

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	\$ 52,965	\$ 25.46	1
2	Assistant Director of Nursing		0			2
3	Registered Nurses	1,215	1,215	21,064	17.34	3
4	Licensed Practical Nurses	10,982	11,101	170,650	15.37	4
5	CNAs & Orderlies	29,998	30,304	247,104	8.15	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,090	2,096	22,659	10.81	9
10	Activity Assistants					10
11	Social Service Workers	2,080	2,080	25,148	12.09	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	23,545	11.32	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,659	9,850	77,294	7.85	15
16	Dishwashers					16
17	Maintenance Workers	2,064	2,080	28,946	13.92	17
18	Housekeepers	5,339	5,339	40,119	7.51	18
19	Laundry	3,451	3,515	29,814	8.48	19
20	Administrator	2,080	2,080	62,068	29.84	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,087	2,087	27,860	13.35	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: <u>Care Plan Coordin</u>	2,080	2,080	35,022	16.84	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	77,285	77,987	\$ 864,258 *	\$ 11.08	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 5,500	9(3)	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 1,200	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)	\$ 6,700		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

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount			
<u>Juli Piper</u>	<u>Administrator</u>	<u>0</u>	\$ <u>62,068</u>	<u>Workers' Compensation Insurance</u>	\$ <u>21,800</u>	<u>IDPH License Fee</u>	\$ <u>1,378</u>			
				<u>Unemployment Compensation Insurance</u>	<u>47,490</u>	<u>Advertising: Employee Recruitment</u>	<u>496</u>			
				<u>FICA Taxes</u>	<u>62,978</u>	<u>Health Care Worker Background Check</u>	<u>2,101</u>			
				<u>Employee Health Insurance</u>	<u>55,291</u>	(Indicate # of checks performed <u>175</u> )				
				<u>Employee Meals</u>	<u>3,632</u>	<u>Patient Background Checks</u>				
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Miscellaneous Dues and Subscriptions</u>	<u>48</u>			
				<u>Employee Retirement</u>	<u>282</u>					
				<u>Employee Relations</u>	<u>4,919</u>					
<b>TOTAL (agree to Schedule V, line 17, col. 1)</b>			<b>\$ <u>62,068</u></b>	<b>TOTAL (agree to Schedule V, line 22, col.8)</b>			<b>\$ <u>196,392</u></b>			
<b>(List each licensed administrator separately.)</b>				<b>TOTAL (agree to Sch. V, line 20, col. 8)</b>			<b>\$ <u>4,736</u></b>			
<b>B. Administrative - Other</b>				<b>E. Schedule of Non-Cash Compensation Paid to Owners or Employees</b>				<b>G. Schedule of Travel and Seminar**</b>		
Description			Amount	Description		Line #	Amount	Description		Amount
<u>Management Fees (Mgmt. fees eliminated in col 7)</u>			\$ <u>36,500</u>	<u>N/A</u>				<u>Out-of-State Travel</u>		\$
								<u>In-State Travel</u>		
<b>TOTAL (agree to Schedule V, line 17, col. 3)</b>			<b>\$ <u>36,500</u></b>	<b>TOTAL</b>				<u>Seminar Expense</u>		<u>99</u>
<b>(Attach a copy of any management service agreement)</b>								<u>Allocated from Home Office</u>		<u>535</u>
<b>C. Professional Services</b>				<b>F. Dues, Fees, Subscriptions and Promotions</b>				<b>G. Schedule of Travel and Seminar**</b>		
Vendor/Payee		Type	Amount	Description		Line #	Amount	Description		Amount
<u>Altschuler, Melvoin &amp;</u>			\$					<u>Entertainment Expense</u>		( )
<u>Glasser, LLP</u>		<u>Accounting</u>	<u>1600</u>					<b>TOTAL (agree to Sch. V, line 24, col. 8)</b>		<b>\$ <u>634</u></b>
<u>Hamilton</u>		<u>Computer Services</u>	<u>444</u>							
<u>LTC Solutions</u>		<u>Computer Services</u>	<u>1850</u>							
<u>Office Ware</u>		<u>Computer Services</u>	<u>236</u>							
<u>Senior Technology</u>		<u>Computer Services</u>	<u>131</u>							
<b>TOTAL (agree to Schedule V, line 19, column 3)</b>			<b>\$ <u>4,261</u></b>							
<b>(If total legal fees exceed \$5,000, attach copy of invoices.)</b>										

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

\*\*See instructions.

Petersen Health Care, Inc. (McLeansboro)  
Provider Number - 0047498  
FYE: 12/31/2006

Schedule 21A

XIX. SUPPORT SCHEDULE  
C. Professional Services

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

4,261

Allocated from Home Office

Other Professional Fees

4,410

Legal

59

Other Professional Fees - PHO

1,816

Legal - PHO

56

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

10,602

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number McLeansboro Rehabilitation & Health Care Center# 0047498Report Period Beginning: 01/01/06Ending: 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? 6 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 1,755 Line 10A
- (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. \$ 23,543  
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. \$ 3,632 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 672
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N?a
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? 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 is 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