

Facility Name & ID Number Newman Rehabilitation & Health Care Center

0047506 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	60	Skilled (SNF)	60	21,900	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	60	TOTALS	60	21,900	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				
		2 Medicaid Recipient	3 Private Pay	4 Other		5 Total
8	SNF	11,825	5,616	1,726	19,167	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,825	5,616	1,726	19,167	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.52%

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 60 and days of care provided 1,726

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 Newman Rehabilitation & Health Care Cente # 0047506 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	99,219	9,539		108,758		108,758	1,904	110,662		1
2	Food Purchase		78,645		78,645		78,645	(6,178)	72,467		2
3	Housekeeping	63,853	10,551		74,404		74,404	61	74,465		3
4	Laundry	12,398	9,038		21,436		21,436		21,436		4
5	Heat and Other Utilities			50,962	50,962		50,962	253	51,215		5
6	Maintenance	32,254	19,639	7,075	58,968		58,968	4,721	63,689		6
7	Other (specify):* Home Office Benefits							1,186	1,186		7
8	TOTAL General Services	207,724	127,412	58,037	393,173		393,173	1,947	395,120		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	573,746	59,240	983	633,969		633,969	5,882	639,851		10
10a	Therapy			149,570	149,570		149,570	452	150,022		10a
11	Activities	30,804	4,085		34,889		34,889		34,889		11
12	Social Services	22,278	84		22,362		22,362		22,362		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Office Benefits							1,850	1,850		15
16	TOTAL Health Care and Programs	626,828	63,409	162,553	852,790		852,790	8,184	860,974		16
	C. General Administration										
17	Administrative	55,734		47,000	102,734		102,734	(32,429)	70,305		17
18	Directors Fees										18
19	Professional Services			10,514	10,514		10,514	8,348	18,862		19
20	Dues, Fees, Subscriptions & Promotions			4,147	4,147		4,147	938	5,085		20
21	Clerical & General Office Expenses	23,864	4,186	22,365	50,415		50,415	27,162	77,577		21
22	Employee Benefits & Payroll Taxes			151,934	151,934		151,934	3,375	155,309		22
23	Inservice Training & Education							175	175		23
24	Travel and Seminar			65	65		65	704	769		24
25	Other Admin. Staff Transportation			2,806	2,806		2,806	2,067	4,873		25
26	Insurance-Prop.Liab.Malpractice			21,342	21,342		21,342	1,081	22,423		26
27	Other (specify):* Home Office Benefits							5,273	5,273		27
28	TOTAL General Administration	79,598	4,186	260,173	343,957		343,957	16,694	360,651		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	914,150	195,007	480,763	1,589,920		1,589,920	26,825	1,616,745		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	
	D. Ownership											
30	Depreciation			3,967	3,967		3,967	6,473	10,440			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			243,866	243,866		243,866	17,359	261,225			32
33	Real Estate Taxes			19,100	19,100		19,100	1,894	20,994			33
34	Rent-Facility & Grounds			189,198	189,198		189,198	862	190,060			34
35	Rent-Equipment & Vehicles			18,181	18,181		18,181	564	18,745			35
36	Other (specify):*											36
37	TOTAL Ownership			474,312	474,312		474,312	27,152	501,464			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		2,042		2,042		2,042		2,042			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			32,850	32,850		32,850		32,850			42
43	Other (specify):* Nonallowable Cost			40,868	40,868		40,868	(40,868)				43
44	TOTAL Special Cost Centers		2,042	73,718	75,760		75,760	(40,868)	34,892			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	914,150	197,049	1,028,793	2,139,992		2,139,992	13,109	2,153,101			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	(2,874)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,425)	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	90	30		9
10	Interest and Other Investment Income	(2,326)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(262)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(31,319)	43		24
25	Fund Raising, Advertising and Promotional	(2,838)	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 <u>See Schedule 5A</u>	(9,068)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (51,022)		\$	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)	64,131		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 64,131		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 13,109		37

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

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

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

BHF USE ONLY					
48	49	50	51	52	

SEE ACCOUNTANTS' COMPILATION REPORT

Newman Rehabilitation & Health Care Center

ID# 0047506

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Nonallowable marketing events	\$ (1,530)	43	1
2	Labs - Part A	(1,776)	43	2
3	X-Rays - Part A	(702)	43	3
4	Marketing Supplies	(15)	43	4
5	Disallow nonallowable travel	(5,045)	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	Total	(9,068)		49

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Newman Rehabilitation & Health Care Center# 0047506

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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	1,363	0	541	0	0	0	0	0	0	0	1,904	1
2	Food Purchase	(2,874)	67	0	4	0	0	0	0	0	0	0	(2,803)	2
3	Housekeeping	0	60	0	1	0	0	0	0	0	0	0	61	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	253	0	0	0	0	0	0	0	0	0	253	5
6	Maintenance	0	3,466	0	1,255	0	0	0	0	0	0	0	4,721	6
7	Other (specify):*	0	546	0	640	0	0	0	0	0	0	0	1,186	7
8	TOTAL General Services	(2,874)	5,755	0	2,441	0	5,322	8						
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	4,927	0	955	0	0	0	0	0	0	0	5,882	10
10a	Therapy	0	452	0	0	0	0	0	0	0	0	0	452	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	1,523	0	327	0	0	0	0	0	0	0	1,850	15
16	TOTAL Health Care and Programs	0	6,902	0	1,282	0	8,184	16						
	C. General Administration													
17	Administrative	0	(33,567)	0	1,138	0	0	0	0	0	0	0	(32,429)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	5,883	0	2,464	0	0	0	0	0	0	0	8,347	19
20	Fees, Subscriptions & Promotions	0	576	0	362	0	0	0	0	0	0	0	938	20
21	Clerical & General Office Expenses	0	0	21,654	5,508	0	0	0	0	0	0	0	27,162	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	175	0	0	0	0	0	0	0	0	175	23
24	Travel and Seminar	(5,045)	0	5,243	506	0	0	0	0	0	0	0	704	24
25	Other Admin. Staff Transportation	0	0	1,395	672	0	0	0	0	0	0	0	2,067	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,032	49	0	0	0	0	0	0	0	1,081	26
27	Other (specify):*	0	0	3,827	1,446	0	0	0	0	0	0	0	5,273	27
28	TOTAL General Administration	(5,045)	(27,108)	33,326	12,145	0	13,318	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(7,919)	(14,451)	33,326	15,868	0	26,824	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Newman Rehabilitation & Health Care Center # 0047506 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	90	0	5,339	1,044	0	0	0	0	0	0	0	6,473	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,326)	0	2,966	16,719	0	0	0	0	0	0	0	17,359	32
33	Real Estate Taxes	0	0	626	1,268	0	0	0	0	0	0	0	1,894	33
34	Rent-Facility & Grounds	0	0	607	255	0	0	0	0	0	0	0	862	34
35	Rent-Equipment & Vehicles	0	0	318	246	0	0	0	0	0	0	0	564	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(2,236)	0	9,856	19,532	0	27,152	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):*	(40,867)	0	0	0	0	0	0	0	0	0	0	(40,867)	43
44	TOTAL Special Cost Centers	(40,867)	0	0	0	0	0	0	0	0	0	0	(40,867)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(51,022)	(14,451)	43,182	35,400	0	13,109	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%	\$ 1,363	\$ 1,363	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	67	67	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	60	60	3
4	V							4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	253	253	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	3,466	3,466	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	546	546	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	4,927	4,927	8
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	452	452	9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,523	1,523	10
11	V	17 Administrative	47,000	Petersen Health Care, Inc.	100.00%	13,433	(33,567)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	5,883	5,883	12
13	V	20 Due, Fees, Subs & Promos		Petersen Health Care, Inc.	100.00%	576	576	13
14	Total		\$ 47,000			\$ 32,549	\$ * (14,451)	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%	\$ 21,654	\$	21,654	15
16	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	175		175	16
17	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	5,243		5,243	17
18	V	25 Other Admin. Staff Transport		Petersen Health Care, Inc.	100.00%	1,395		1,395	18
19	V	26 Insurance-Prop.Liab.Malpractice		Petersen Health Care, Inc.	100.00%	1,032		1,032	19
20	V	27 Mgmt Allocation of Benefits		Petersen Health Care, Inc.	100.00%	3,827		3,827	20
21	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	5,339		5,339	21
22	V	32 Interest		Petersen Health Care, Inc.	100.00%	2,966		2,966	22
23	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	626		626	23
24	V	34 Rent - Facility & Grounds		Petersen Health Care, Inc.	100.00%	607		607	24
25	V	35 Rent - Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	318		318	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		\$			\$ 43,182	\$ *	43,182	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> Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 541	\$	541	15
16	V	<u>2</u> Food		Petersen Health Care, Inc.	100.00%	4		4	16
17	V	<u>3</u> Housekeeping		Petersen Health Care, Inc.	100.00%	1		1	17
18	V								18
19	V								19
20	V	<u>6</u> Maintenance		Petersen Health Care, Inc.	100.00%	1,255		1,255	20
21	V	<u>7</u> Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	640		640	21
22	V	<u>10</u> Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	955		955	22
23	V	<u>10A</u> Therapy		Petersen Health Care, Inc.	100.00%	0		0	23
24	V	<u>15</u> Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	327		327	24
25	V	<u>17</u> Administrative		Petersen Health Care, Inc.	100.00%	1,138		1,138	25
26	V	<u>19</u> Professional Services		Petersen Health Care, Inc.	100.00%	2,464		2,464	26
27	V	<u>20</u> Due, Fees, Subs & Promos		Petersen Health Care, Inc.	100.00%	362		362	27
28	V	<u>21</u> Clerical & General Office		Petersen Health Care, Inc.	100.00%	5,508		5,508	28
29	V								29
30	V	<u>24</u> Travel and Seminar		Petersen Health Care, Inc.	100.00%	506		506	30
31	V	<u>25</u> Other Admin. Staff Transport		Petersen Health Care, Inc.	100.00%	672		672	31
32	V	<u>26</u> Insurance-Prop.Liab.Malpractice		Petersen Health Care, Inc.	100.00%	49		49	32
33	V	<u>27</u> Mgmt Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,446		1,446	33
34	V	<u>30</u> Depreciation		Petersen Health Care, Inc.	100.00%	1,044		1,044	34
35	V	<u>32</u> Interest		Petersen Health Care, Inc.	100.00%	16,719		16,719	35
36	V	<u>33</u> Real Estate Taxes		Petersen Health Care, Inc.	100.00%	1,268		1,268	36
37	V	<u>34</u> Rent - Facility & Grounds		Petersen Health Care, Inc.	100.00%	255		255	37
38	V	<u>35</u> Rent - Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	246		246	38
39	Total		\$			\$ 35,400	\$ *	35,400	39

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

Facility Name & ID Number Newman Rehabilitation & Health Care Cent # 0047506 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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	0.84	1.68	Salary	\$ 13,433	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	\$ 13,433		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 Newman Rehabilitation & Health Care Center# 0047506

Report Period Beginning:

01/01/2006Ending: 2/31/2006

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization

Petersen Health Care, Inc.

Street Address

830 West Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309) 691-8113

Fax Number

(309) 691-8622

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Patient Days	1,141,512	56	\$ 81,179	\$ 80,967	19,167	\$ 1,363	1
2	2	Food	Patient Days	1,141,512	56	3,989	19,167	67		2
3	3	Housekeeping	Patient Days	1,141,512	56	3,589	19,167	60		3
4	4	Laundry	Patient Days	1,141,512	56	0	19,167	0		4
5	5	Utilities	Patient Days	1,141,512	56	15,054	19,167	253		5
6	6	Maintenance	Patient Days	1,141,512	56	206,416	110,513	19,167	3,466	6
7	7	Mgmt. Allocation of Benefits	Patient Days	1,141,512	56	32,526	19,167	546		7
8	10	Nursing and Medical Records	Patient Days	1,141,512	56	293,462	289,197	19,167	4,927	8
9	10A	Therapy	Patient Days	1,141,512	56	26,945	19,167	452		9
10	15	Mgmt. Allocation of Benefits	Patient Days	1,141,512	56	90,724	19,167	1,523		10
11	17	Administrative	Patient Days	1,141,512	56	800,000	800,000	19,167	13,433	11
12	19	Professional Services	Patient Days	1,141,512	56	350,361	4,303	19,167	5,883	12
13	20	Due, Fees, Subs & Promos	Patient Days	1,141,512	56	34,325	19,167	576		13
14	21	Clerical & General Office	Patient Days	1,141,512	56	1,289,623	954,322	19,167	21,654	14
15	23	Inservice Training & Education	Patient Days	1,141,512	56	10,426	19,167	175		15
16	24	Travel and Seminar	Patient Days	1,141,512	56	312,259	19,167	5,243		16
17	25	Other Admin. Staff Transport	Patient Days	1,141,512	56	83,062	19,167	1,395		17
18	26	Insurance-Prop.Liab.Malpractice	Patient Days	1,141,512	56	61,457	19,167	1,032		18
19	27	Mgmt Allocation of Benefits	Patient Days	1,141,512	56	227,912	19,167	3,827		19
20	30	Depreciation	Patient Days	1,141,512	56	317,964	19,167	5,339		20
21	32	Interest	Patient Days	1,141,512	56	176,614	19,167	2,966		21
22	33	Real Estate Taxes	Patient Days	1,141,512	56	37,282	19,167	626		22
23	34	Rent - Facility & Grounds	Patient Days	1,141,512	56	36,133	19,167	607		23
24	35	Rent - Equipment & Vehicles	Patient Days	1,141,512	56	18,933	19,167	318		24
25	TOTALS					\$ 4,510,235	\$ 2,239,302		\$ 75,731	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Newman Rehabilitation & Health Care Center

0047506

Report Period Beginning:

01/01/2006

Ending: 2/31/2006

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization Petersen Health Care, Inc.
 Street Address 830 West Trailcreek Drive
 City / State / Zip Code Peoria, IL 61614
 Phone Number (309) 691-8113
 Fax Number (309) 691-8622

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Patient Days	427,669	46	\$ 12,081	\$ 11,958	19,167	\$ 541	1
2	2	Food	Patient Days	427,669	46	93	19,167	4		2
3	3	Housekeeping	Patient Days	427,669	46	28	19,167	1		3
4										4
5										5
6	6	Maintenance	Patient Days	427,669	46	28,012	28,012	19,167	1,255	6
7	7	Mgmt. Allocation of Benefits	Patient Days	427,669	46	14,282	19,167	640		7
8	10	Nursing and Medical Records	Patient Days	427,669	46	21,299	20,434	19,167	955	8
9	10A	Therapy	Patient Days	427,669	46		19,167			9
10	15	Mgmt. Allocation of Benefits	Patient Days	427,669	46	7,301	19,167	327		10
11	17	Administrative	Patient Days	427,669	46	25,391	25,391	19,167	1,138	11
12	19	Professional Services	Patient Days	427,669	46	54,971	19,167	2,464		12
13	20	Due, Fees, Subs & Promos	Patient Days	427,669	46	8,088	19,167	362		13
14	21	Clerical & General Office	Patient Days	427,669	46	122,893	64,907	19,167	5,508	14
15										15
16	24	Travel and Seminar	Patient Days	427,669	46	11,280	19,167	506		16
17	25	Other Admin. Staff Transport	Patient Days	427,669	46	15,003	19,167	672		17
18	26	Insurance-Prop.Liab.Malpractice	Patient Days	427,669	46	1,087	19,167	49		18
19	27	Mgmt Allocation of Benefits	Patient Days	427,669	46	32,265	19,167	1,446		19
20	30	Depreciation	Patient Days	427,669	46	23,301	19,167	1,044		20
21	32	Interest	Patient Days	427,669	46	373,049	19,167	16,719		21
22	33	Real Estate Taxes	Patient Days	427,669	46	28,282	19,167	1,268		22
23	34	Rent - Facility & Grounds	Patient Days	427,669	46	5,700	19,167	255		23
24	35	Rent - Equipment & Vehicles	Patient Days	427,669	46	5,479	19,167	246		24
25	TOTALS					\$ 789,885	\$ 150,702		\$ 35,400	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	LaSalle Bank		X	Mortgage	Varies	09/30/05	\$ 490,000	\$ 482,847	09/20/10	Varies	\$ 42,037	1								
2	Ziegler Healthcare		X	Mortgage	Varies	09/30/05	90,000	89,835	09/20/10	0.1000	13,729	2								
3												3								
4							Allocation from Home Office				19,685	4								
5							Offset Interest Income				(2,326)	5								
Working Capital																				
6							Amortization Expense				188,100	6								
7												7								
8												8								
9	TOTAL Facility Related						\$ 580,000	\$ 572,682			\$ 261,225	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 580,000	\$ 572,682			\$ 261,225	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.

\$ **19,096** 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 \$ **19,096** 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.)

\$ **19,100** 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

1,894

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.

\$ **20,994** 7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

2001	<u> </u>	8
2002	<u> </u>	9
2003	<u> </u>	10
2004	<u> </u>	11
2005	19,096	12

Tax Accrual based on Prior Year Tax Bill

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 Newman Rehabilitation & Health Care Center COUNTY Douglas

FACILITY IDPH LICENSE NUMBER 0047506

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>07-06-31-400-012</u>	<u>Nursing Home</u>	\$ <u>19,096.20</u>	\$ <u>19,096.20</u>
2. _____	<u>Home Office Allocation</u>	\$ _____	\$ <u>1,894.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>19,096.20</u>	\$ <u>20,990.20</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: 20,206 B. General Construction Type: Exterior Brick Frame Protected 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: _____
 (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>20,206</u>	<u>2005</u>	\$	<u>1</u>
2					<u>2</u>
3	TOTALS	20,206		\$	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4				\$	\$		\$	\$	\$
5									
6	Home Office Allocation		2006	11,431			500	500	500
7									
8									
	Improvement Type**								
9	Sidewalks		2006	5,535		8	346	346	346
10	2 Rooftop A/C		2006	11,726		5	1,173	1,173	1,173
11									
12	Land Improvement Booked				154			(154)	
13									
14	Building Improvement Booked				1,173			(1,173)	
15									
16									
17									
18	2006 - Home Office Allocation - Building Improvements		2006	680			62	62	62
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 29,372	\$ 1,327		\$ 2,081	\$ 754	\$ 2,081	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	\$ 7,000	\$ 2,641	\$ 2,333	\$ (308)	4	\$ 3,499	71
72	Current Year Purchases	2,049		205	205	5	205	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			5,821	5,821			74
75	TOTALS	\$ 9,049	\$ 2,641	\$ 8,359	\$ 5,718		\$ 3,704	75

D. Vehicle Depreciation (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 38,421	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 3,968	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 10,440	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 6,472	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,785	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$ N/A	92
93			93
94			94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Springwood Associates Limited Partnership

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? YES NO

If NO, see instructions.

	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:		<u>12/01/92</u>	\$ <u>189,198</u>	<u>16</u>	<u>N/A</u>	3
4	Additions						4
5	<u>2006 Home Office Allocation</u>			<u>862</u>			5
6							6
7	TOTAL			\$ <u>190,060</u>			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 by the length of the lease _____.

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: \$ 18,745 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			<u>N/A</u>		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.

Newman Rehabilitation & Health Care Center
Provider Number - 0047506
FYE: 12/31/2006

Schedule 14A

Line 16: Rental Amount of Moveable Equipment

Description	Amount
Copier	4,095
Dishwasher	708
Septic Pump	528
Water Conditioner	396
Carpet Extractor	132
Medical Equip.	1,079
Medical Equip.	8,885
Medical Equip.	260
Medical Equip.	2,290
Other	54
Home Office Allocation	318
	<u>18,745</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? <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. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A,3	hrs	\$	828	\$ 64,145	\$	828	\$ 64,145	1
2	Licensed Speech and Language Development Therapist	10A,3	hrs		35	2,806		35	2,806	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A,3	hrs		784	68,317		784	68,317	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <u>Oxygen</u>	39,2					2,042		2,042	13
14	TOTAL			\$	1,647	\$ 135,268	\$ 2,042	1,647	\$ 137,310	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

Newman Rehabilitation & Health Care Center
Provider Number - 0047506
FYE: 12/31/2006

Schedule 17A

Other Current Liabilities(specify):

Line 36

	Operating	After Consolidation
Fica W/h & Empl Fica	2,879	2,879
Federal Withholding	3,022	3,022
State W/h - IL	2,249	2,249
Wage Garnishment	197	197
Other Withholdings	2,039	2,039
	<u>10,386</u>	<u>10,386</u>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 45,089	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 45,089	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	194,214	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Rounding	2	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 194,216	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)	\$ 239,305	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	\$ 1,949,542	1
2	Discounts and Allowances for all Levels	43,885	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,993,427	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	244,722	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 244,722	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants	31,205	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,874	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	54,489	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	3,865	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 92,433	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,326	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,326	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous</u>	1,298	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,298	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,334,206	30

2

Expenses		Amount	
A. Operating Expenses			
31	General Services	393,173	31
32	Health Care	852,790	32
33	General Administration	343,957	33
B. Capital Expense			
34	Ownership	474,312	34
C. Ancillary Expense			
35	Special Cost Centers	42,910	35
36	Provider Participation Fee	32,850	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,139,992	40
41	Income before Income Taxes (line 30 minus line 40)**	194,214	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 194,214	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.
Entity is a cash basis taxpayer

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

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

Facility Name & ID Number Newman Rehabilitation & Health Care Center

0047506

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

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	\$ 60,196	\$ 28.94	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,990	2,990	60,241	20.15	3
4	Licensed Practical Nurses	5,961	5,993	111,244	18.56	4
5	CNAs & Orderlies	31,502	32,191	303,611	9.43	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,930	1,950	24,325	12.48	9
10	Activity Assistants	865	865	6,479	7.49	10
11	Social Service Workers	2,077	2,077	22,278	10.73	11
12	Dietician					12
13	Food Service Supervisor	1,650	1,690	22,362	13.24	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,838	9,588	76,857	8.02	15
16	Dishwashers					16
17	Maintenance Workers	2,043	2,083	32,254	15.49	17
18	Housekeepers	9,463	9,596	63,853	6.65	18
19	Laundry	1,691	1,728	12,398	7.17	19
20	Administrator	2,019	2,019	55,734	27.61	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,845	1,949	23,864	12.24	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>	2,456	2,568	38,454	14.97	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	78,406	79,364	\$ 914,150 *	\$ 11.52	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	\$		35	
36	Medical Director	Monthly 12,000	9,3	36	
37	Medical Records Consultant			37	
38	Nurse Consultant			38	
39	Pharmacist Consultant	Monthly 983	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	<u>Rehab Consultant</u>	286	14,303	10A,3	47
48				48	
49	TOTAL (lines 35 - 48)	286	\$ 27,286		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	
Claire Matheny	Administrator	0	\$ 42,399	Workers' Compensation Insurance	\$ 25,160	IDPH License Fee	\$ 1,879	
Joan Darr	Administrator	0	13,335	Unemployment Compensation Insurance	52,405	Advertising: Employee Recruitment	1,068	
				FICA Taxes	67,137	Health Care Worker Background Check (Indicate # of checks performed <u>100</u>)	1,200	
				Employee Health Insurance	2,959	Patient Background Checks		
				Employee Meals	3,375			
				Illinois Municipal Retirement Fund (IMRF)*				
				Employee Relations	4,273			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 55,734			2006 Home Office Allocation	938	
B. Administrative - Other						Less: Public Relations Expense	()	
Description			Amount			Non-allowable advertising	()	
Management Fee Expense	(Fee eliminated in Col. 7)		\$ 47,000			Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 47,000			TOTAL (agree to Sch. V, line 20, col. 8)	\$ 5,085	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Altschuler, Melvoin & Glasser, LLP	Accounting		1,600	N/A			Out-of-State Travel	\$
RSM McGladrey, Inc.	Computer Services		6,312					
LTC Solutions	Computer Services		1,850				In-State Travel	
Verizon North	Computer Services		86					
ECIC Monthly Internet Access	Computer Services		627				Seminar Expense	65
The Newman Independent	Computer Services		39				2006 Home Office Allocation	704
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 10,514	TOTAL		\$	Entertainment Expense (agree to Sch. V, line 24, col. 8)	()
							TOTAL	\$ 769

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Petersen Health Care, Inc. (Newman Hlth Cntr)
Provider Number - 0047506
FYE: 12/31/2006

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Total (agree to Schedule V, line 19, column 3) 10,514

Allocated from Home Office

Other Professional Fees	5,807
Legal	78
Other Professional Fees - PHO	2,390
Legal - PHO	73

8,348

Total (agree to Schedule V, line 19, column 8) 18,862

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 Newman Rehabilitation & Health Care Center

0047506

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

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? Y
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 472 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. \$ 32,850
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. \$ 3,375 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,874
- (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?
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli & Co The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit currently in progress
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees