



Facility Name & ID Number Sugar Creek Care Center

# 0047571 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	<u>13</u>	Skilled (SNF)	<u>13</u>	<u>4,745</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>63</u>	Intermediate (ICF)	<u>63</u>	<u>22,995</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>76</u>	TOTALS	<u>76</u>	<u>27,740</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>1,180</u>	<u>1,180</u>	8
9	SNF/PED					9
10	ICF	<u>5,978</u>	<u>1,469</u>		<u>7,447</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>5,978</u>	<u>1,469</u>	<u>1,180</u>	<u>8,627</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 31.10%

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 13 and days of care provided 1,180

Medicare Intermediary National Government Service

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 Sugar Creek Care Center # 0047571 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
	<b>A. General Services</b>										
1	Dietary	74,506	4,540	1,143	80,189		80,189	857	81,046		1
2	Food Purchase		35,260		35,260		35,260	(5,350)	29,910		2
3	Housekeeping	54,995	8,034		63,029		63,029	28	63,057		3
4	Laundry	13,251	3,505		16,756		16,756		16,756		4
5	Heat and Other Utilities			41,989	41,989		41,989	114	42,103		5
6	Maintenance	25,642	21,308	5,098	52,048		52,048	2,125	54,173		6
7	Other (specify):* <b>Home Office Benefits</b>							534	534		7
8	<b>TOTAL General Services</b>	168,394	72,647	48,230	289,271		289,271	(1,692)	287,579		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	410,007	52,155	3,860	466,022		466,022	2,646	468,668		10
10a	Therapy			44,116	44,116		44,116	204	44,320		10a
11	Activities	18,207	851	1,066	20,124		20,124		20,124		11
12	Social Services	17,071	181		17,252		17,252		17,252		12
13	CNA Training										13
14	Program Transportation			34	34		34		34		14
15	Other (specify):* <b>Home Office Benefits</b>							833	833		15
16	<b>TOTAL Health Care and Programs</b>	445,285	53,187	55,076	553,548		553,548	3,683	557,231		16
	<b>C. General Administration</b>										
17	Administrative	53,823		22,500	76,323		76,323	(15,942)	60,381		17
18	Directors Fees										18
19	Professional Services			4,835	4,835		4,835	3,757	8,592		19
20	Dues, Fees, Subscriptions & Promotions			1,564	1,564		1,564	422	1,986		20
21	Clerical & General Office Expenses	16,655	3,153	8,844	28,652		28,652	12,226	40,878		21
22	Employee Benefits & Payroll Taxes			115,926	115,926		115,926	3,257	119,183		22
23	Inservice Training & Education							79	79		23
24	Travel and Seminar							317	317		24
25	Other Admin. Staff Transportation			1,403	1,403		1,403	931	2,334		25
26	Insurance-Prop.Liab.Malpractice			12,400	12,400		12,400	487	12,887		26
27	Other (specify):* <b>Home Office Benefits</b>							2,374	2,374		27
28	<b>TOTAL General Administration</b>	70,478	3,153	167,472	241,103		241,103	7,908	249,011		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	684,157	128,987	270,778	1,083,922		1,083,922	9,899	1,093,821		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

Facility Name &amp; ID Number

Sugar Creek Care Center

#0047571

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

## 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			70,461	70,461		70,461	2,587	73,048			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			122,254	122,254		122,254	8,066	130,320			32
33	Real Estate Taxes			30,600	30,600		30,600	852	31,452			33
34	Rent-Facility & Grounds							388	388			34
35	Rent-Equipment & Vehicles			6,556	6,556		6,556	254	6,810			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			229,871	229,871		229,871	12,147	242,018			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,439		1,439		1,439		1,439			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			41,610	41,610		41,610		41,610			42
43	Other (specify):* <b>Nonallowable Cost</b>			25,820	25,820		25,820	(25,820)				43
44	<b>TOTAL Special Cost Centers</b>		1,439	67,430	68,869		68,869	(25,820)	43,049			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	684,157	130,426	568,079	1,382,662		1,382,662	(3,774)	1,378,888			45

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sugar Creek Care Center

# 0047571

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

**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	(2,125)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,845)	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	(286)	30		9
10	Interest and Other Investment Income	(794)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(151)	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	(50)	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	(12,840)	43		24
25	Fund Raising, Advertising and Promotional	(1,378)	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 Page 5A</u>	(10,827)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (31,296)		\$	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)	27,522		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 27,522		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (3,774)		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

Sugar Creek Care Center

ID# 0047571

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Non Allowable Marketing	\$ (2,531)	43	1
2	Labs - Part A	(4,727)	43	2
3	X-rays - Part A	(654)	43	3
4	Marketing Supplies	(644)	43	4
5	Non Allowable Travel Expense	(2,271)	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
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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>	(10,827)		49

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sugar Creek Care Center# 0047571

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	614	0	243	0	0	0	0	0	0	0	857	1
2	Food Purchase	(2,125)	30	0	2	0	0	0	0	0	0	0	(2,093)	2
3	Housekeeping	0	27	0	1	0	0	0	0	0	0	0	28	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	114	0	0	0	0	0	0	0	0	0	114	5
6	Maintenance	0	1,560	0	565	0	0	0	0	0	0	0	2,125	6
7	Other (specify):*	0	246	0	288	0	0	0	0	0	0	0	534	7
8	<b>TOTAL General Services</b>	<b>(2,125)</b>	<b>2,591</b>	<b>0</b>	<b>1,099</b>	<b>0</b>	<b>1,565</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	2,217	0	429	0	0	0	0	0	0	0	2,646	10
10a	Therapy	0	204	0	0	0	0	0	0	0	0	0	204	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	686	0	147	0	0	0	0	0	0	0	833	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>3,107</b>	<b>0</b>	<b>576</b>	<b>0</b>	<b>3,683</b>	<b>16</b>						
	<b>C. General Administration</b>													
17	Administrative	0	(16,454)	0	512	0	0	0	0	0	0	0	(15,942)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	2,648	0	1,109	0	0	0	0	0	0	0	3,757	19
20	Fees, Subscriptions & Promotions	0	259	0	163	0	0	0	0	0	0	0	422	20
21	Clerical & General Office Expenses	0	0	9,747	2,479	0	0	0	0	0	0	0	12,226	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	79	0	0	0	0	0	0	0	0	79	23
24	Travel and Seminar	(2,271)	0	2,360	228	0	0	0	0	0	0	0	317	24
25	Other Admin. Staff Transportation	0	0	628	303	0	0	0	0	0	0	0	931	25
26	Insurance-Prop.Liab.Malpractice	0	0	465	22	0	0	0	0	0	0	0	487	26
27	Other (specify):*	0	0	1,723	651	0	0	0	0	0	0	0	2,374	27
28	<b>TOTAL General Administration</b>	<b>(2,271)</b>	<b>(13,547)</b>	<b>15,002</b>	<b>5,467</b>	<b>0</b>	<b>4,651</b>	<b>28</b>						
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(4,396)</b>	<b>(7,849)</b>	<b>15,002</b>	<b>7,142</b>	<b>0</b>	<b>9,899</b>	<b>29</b>						

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sugar Creek Care Center# 0047571

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(286)	0	2,403	470	0	0	0	0	0	0	0	2,587	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(794)	0	1,335	7,525	0	0	0	0	0	0	0	8,066	32
33	Real Estate Taxes	0	0	281	0	571	0	0	0	0	0	0	852	33
34	Rent-Facility & Grounds	0	0	273	0	115	0	0	0	0	0	0	388	34
35	Rent-Equipment & Vehicles	0	0	143	0	111	0	0	0	0	0	0	254	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(1,080)</b>	<b>0</b>	<b>4,435</b>	<b>7,995</b>	<b>797</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>12,147</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):*	(25,820)	0	0	0	0	0	0	0	0	0	0	(25,820)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(25,820)</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>(25,820)</b>	<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(31,296)</b>	<b>(7,849)</b>	<b>19,437</b>	<b>15,137</b>	<b>797</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(3,774)</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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 614	\$ 614	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	30	30	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	27	27	3
4	V							4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	114	114	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	1,560	1,560	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	246	246	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	2,217	2,217	8
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	204	204	9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	686	686	10
11	V	17 Administrative	22,500	Petersen Health Care, Inc.	100.00%	6,046	(16,454)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	2,648	2,648	12
13	V	20 Due, Fees, Subs & Promos		Petersen Health Care, Inc.	100.00%	259	259	13
14	Total		\$ 22,500			\$ 14,651	\$ * (7,849)	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%	\$ 9,747	\$ 9,747
16	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	79	79
17	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	2,360	2,360
18	V	25 Other Admin. Staff Transport		Petersen Health Care, Inc.	100.00%	628	628
19	V	26 Insurance-Prop.Liab.Malpractice		Petersen Health Care, Inc.	100.00%	465	465
20	V	27 Mgmt Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,723	1,723
21	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	2,403	2,403
22	V	32 Interest		Petersen Health Care, Inc.	100.00%	1,335	1,335
23	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	281	281
24	V	34 Rent - Facility & Grounds		Petersen Health Care, Inc.	100.00%	273	273
25	V	35 Rent - Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	143	143
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	<b>Total</b>		\$			\$ 19,437	\$ * 19,437

\* 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	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 243	\$	243	15
16	V	2 Food		Petersen Health Care, Inc.	100.00%	2		2	16
17	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	1		1	17
18	V								18
19	V								19
20	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	565		565	20
21	V	7 Other		Petersen Health Care, Inc.	100.00%	288		288	21
22	V	10 Nursing & Medical Records		Petersen Health Care, Inc.	100.00%	429		429	22
23	V								23
24	V								24
25	V	15 Other		Petersen Health Care, Inc.	100.00%	147		147	25
26	V	17 Administrative		Petersen Health Care, Inc.	100.00%	512		512	26
27	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	1,109		1,109	27
28	V	20 Dues, Fees, Subscriptions & Promotions		Petersen Health Care, Inc.	100.00%	163		163	28
29	V	21 Clerical & General Office Expenses		Petersen Health Care, Inc.	100.00%	2,479		2,479	29
30	V								30
31	V								31
32	V	24 Travel & Seminar		Petersen Health Care, Inc.	100.00%	228		228	32
33	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	303		303	33
34	V	26 Insurance-Prop, Liab & Malpractice		Petersen Health Care, Inc.	100.00%	22		22	34
35	V	27 Other		Petersen Health Care, Inc.	100.00%	651		651	35
36	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	470		470	36
37	V	32 Interest		Petersen Health Care, Inc.	100.00%	7,525		7,525	37
38	V								38
39	Total		\$			\$ 15,137	\$ *	15,137	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	33 Real Estate Taxes	\$	Petersen Health Care, Inc.	100.00%	\$ 571	\$	571	15
16	V	34 Rent - Facility & Grounds		Petersen Health Care, Inc.	100.00%	115		115	16
17	V	35 Rent - Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	111		111	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								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	<b>Total</b>		\$			\$ 797	\$ *	797	39

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

Facility Name &amp; ID Number

Sugar Creek Care Center

# 0047571

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	0.38	0.76	Salary	\$ 6,046	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	\$ 6,046		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 Sugar Creek Care Center

# 0047571

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	1,141,463	56	\$ 81,179	\$ 80,967	8,627	\$ 614	1
2	2	Food	Patient Days	1,141,463	56	3,989		8,627	30	2
3	3	Housekeeping	Patient Days	1,141,463	56	3,589		8,627	27	3
4										4
5	5	Utilities	Patient Days	1,141,463	56	15,054		8,627	114	5
6	6	Maintenance	Patient Days	1,141,463	56	206,416	110,513	8,627	1,560	6
7	7	Mgmt. Allocation of Benefits	Patient Days	1,141,463	56	32,526		8,627	246	7
8	10	Nursing and Medical Records	Patient Days	1,141,463	56	293,462	289,197	8,627	2,218	8
9	10A	Therapy	Patient Days	1,141,463	56	26,945		8,627	204	9
10	15	Mgmt. Allocation of Benefits	Patient Days	1,141,463	56	90,724		8,627	686	10
11	17	Administrative	Patient Days	1,141,463	56	800,000	800,000	8,627	6,046	11
12	19	Professional Services	Patient Days	1,141,463	56	350,361	4,303	8,627	2,648	12
13	20	Due, Fees, Subs & Promos	Patient Days	1,141,463	56	34,325		8,627	259	13
14	21	Clerical & General Office	Patient Days	1,141,463	56	1,289,623	954,322	8,627	9,747	14
15	23	Inservice Training & Education	Patient Days	1,141,463	56	10,426		8,627	79	15
16	24	Travel and Seminar	Patient Days	1,141,463	56	312,259		8,627	2,360	16
17	25	Other Admin. Staff Transport	Patient Days	1,141,463	56	83,062		8,627	628	17
18	26	Insurance-Prop.Liab.Malpractice	Patient Days	1,141,463	56	61,457		8,627	464	18
19	27	Mgmt Allocation of Benefits	Patient Days	1,141,463	56	227,912		8,627	1,723	19
20	30	Depreciation	Patient Days	1,141,463	56	317,964		8,627	2,403	20
21	32	Interest	Patient Days	1,141,463	56	176,614		8,627	1,335	21
22	33	Real Estate Taxes	Patient Days	1,141,463	56	37,282		8,627	282	22
23	34	Rent - Facility & Grounds	Patient Days	1,141,463	56	36,133		8,627	273	23
24	35	Rent - Equipment & Vehicles	Patient Days	1,141,463	56	18,933		8,627	143	24
25	TOTALS					\$ 4,510,235	\$ 2,239,302		\$ 34,089	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sugar Creek Care Center

# 0047571

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	8,627	\$ 244	1
2	2	Food	Patient Days	427,669	46	93		8,627	2	2
3	3	Housekeeping	Patient Days	427,669	46	28		8,627	1	3
4	6	Maintenance	Patient Days	427,669	46	28,012	28,012	8,627	565	4
5	7	Mgmt. Allocation of Benefits	Patient Days	427,669	46	14,282		8,627	288	5
6	10	Nursing and Medical Records	Patient Days	427,669	46	21,299	20,434	8,627	430	6
7										7
8	15	Mgmt. Allocation of Benefits	Patient Days	427,669	46	7,301		8,627	147	8
9	17	Administrative	Patient Days	427,669	46	25,391	25,391	8,627	512	9
10	19	Professional Services	Patient Days	427,669	46	54,971		8,627	1,109	10
11	20	Due, Fees, Subs & Promos	Patient Days	427,669	46	8,088		8,627	163	11
12	21	Clerical & General Office	Patient Days	427,669	46	122,893	64,907	8,627	2,479	12
13										13
14	24	Travel and Seminar	Patient Days	427,669	46	11,280		8,627	228	14
15	25	Other Admin. Staff Transport	Patient Days	427,669	46	15,003		8,627	303	15
16	26	Insurance-Prop.Liab.Malpractice	Patient Days	427,669	46	1,087		8,627	22	16
17	27	Mgmt Allocation of Benefits	Patient Days	427,669	46	32,265		8,627	651	17
18	30	Depreciation	Patient Days	427,669	46	23,301		8,627	470	18
19	32	Interest	Patient Days	427,669	46	373,049		8,627	7,525	19
20	33	Real Estate Taxes	Patient Days	427,669	46	28,282		8,627	571	20
21	34	Rent - Facility & Grounds	Patient Days	427,669	46	5,700		8,627	115	21
22	35	Rent - Equipment & Vehicles	Patient Days	427,669	46	5,479		8,627	111	22
23										23
24										24
25	TOTALS					\$ 789,885	\$ 150,702		\$ 15,936	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sugar Creek Care Center

# 0047571 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

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

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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
2									2
3									3
4									4
5									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	<b>TOTALS</b>				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Sugar Creek Care Center

# 0047571

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

**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**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	LaSalle Bank		X	Mortgage	Varies	09/30/05	\$ 1,070,000	\$ 1,054,381	09/20/10	Varies	\$ 102,254	1						
2	Ziegler Healthcare		X	Mortgage	Varies	09/30/05	200,000	199,634	09/20/10	0.1000	20,000	2						
3												3						
4							Allocation from Home Office				8,860	4						
5							Offset Interest Income				(794)	5						
<b>Working Capital</b>																		
6												6						
7												7						
8												8						
9	<b>TOTAL Facility Related</b>						\$ 1,270,000	\$ 1,254,015			\$ 130,320	9						
<b>B. Non-Facility Related*</b>																		
10												10						
11												11						
12												12						
13												13						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14						
15	<b>TOTALS (line 9+line14)</b>						\$ 1,270,000	\$ 1,254,015			\$ 130,320	15						

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

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

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)



**IMPORTANT NOTICE**

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

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

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

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

**2005 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Sugar Creek Care Center COUNTY Iroquois

FACILITY IDPH LICENSE NUMBER 0047571

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>17C-1931227003</u>	<u>Nursing Home</u>	\$ <u>30,645.94</u>	\$ <u>30,645.94</u>
2. _____	<u>Home Office Allocation</u>	\$ _____	\$ <u>852.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>30,645.94</u>	\$ <u>31,497.94</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.

Facility Name & ID Number Sugar Creek Care Center

# 0047571

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 16,089 B. General Construction Type: Exterior Brick Frame Wood Number of Stories One

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

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

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

None

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

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

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

**XI. OWNERSHIP COSTS:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>98,881</u>	<u>2005</u>	<u>\$ 56,250</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>98,881</b>		<b>\$ 56,250</b>	<b>3</b>

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	76	2005	1969	\$ 1,008,250	\$	25	\$ 40,330	\$ 40,330	\$ 60,495	4
5										5
6	Home Office Allocation		2006	5,145			225	225	225	6
7										7
8										8
<b>Improvement Type**</b>										
9	Original Land Improvements		2005	15,000		15	1,000	1,000	1,500	9
10										10
11	Land Improvement Booked				1,000			(1,000)		11
12	Building Booked				40,357			(40,357)		12
13										13
14	Home Office Allocation		2006	305			29	29	29	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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 1,028,700	\$ 41,357		\$ 41,584	\$ 227	\$ 62,249	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sugar Creek Care Center

# 0047571

Report Period Beginning:

01/01/2006

Ending:

12/31/2006

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	\$ 194,928	\$ 29,104	\$ 28,507	\$ (597)	Various	\$ 42,760	71
72	Current Year Purchases	4,732		338	338	Various	338	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			2,619	2,619			74
75	TOTALS	\$ 199,660	\$ 29,104	\$ 31,464	\$ 2,360		\$ 43,098	75

D. Vehicle Depreciation (See instructions.)\*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,284,610	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 70,461	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 73,048	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,587	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 105,347	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.

SEE ACCOUNTANTS' COMPILATION REPORT

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Home Office Allocation				388			5
6								6
7	TOTAL				\$ 388			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: \_\_\_\_\_ \*

**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: \$ 6,810 Description: Dishwasher 236; Copier 3061; Nursing Equip 3,259; Home Office Allocation 254

(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>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	<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	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service			Units	Cost									
1	Licensed Occupational Therapist	10A,3	0	hrs	\$	194	\$ 15,472	\$	194	\$	15,472	1				
2	Licensed Speech and Language Development Therapist	10A,3	0	hrs		45	3,930		45		3,930	2				
3	Licensed Recreational Therapist			hrs								3				
4	Licensed Physical Therapist	10A,3	0	hrs		319	24,714		319		24,714	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							1,439		1,439	13				
14	TOTAL				\$	558	\$ 44,116	\$	1,439	\$	45,555	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 &amp; ID Number Sugar Creek Care Center

# 0047571

Report Period Beginning: 01/01/2006

Ending:

12/31/2006

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2006

(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	\$ 375	\$ 375	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>None</u> )	220,473	220,473	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	8,854	8,854	7
8	Accounts Receivable (owners or related parties)	3,290	3,290	8
9	Other(specify): _____			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 232,992	\$ 232,992	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	71,250	56,555	13
14	Buildings, at Historical Cost	1,008,250	1,028,395	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	199,660	199,660	16
17	Accumulated Depreciation (book methods)	(85,554)	(105,347)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify): _____			22
23	Other(specify): _____			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 1,193,606	\$ 1,179,263	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 1,426,598	\$ 1,412,255	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 444,444	\$ 444,444	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	13,458	13,458	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,547	6,547	31
32	Accrued Real Estate Taxes(Sch.IX-B)	30,600	30,600	32
33	Accrued Interest Payable	13,040	13,040	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Accrued expenses</u>	11,264	11,264	36
37	_____			37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 519,353	\$ 519,353	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable	199,634	199,634	40
41	Bonds Payable	1,054,381	1,054,381	41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	_____			43
44	_____			44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 1,254,015	\$ 1,254,015	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 1,773,368	\$ 1,773,368	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ (346,770)	\$ (361,113)	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 1,426,598	\$ 1,412,255	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(47,880)</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>(47,880)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(298,890)</b>	<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>(298,890)</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>(346,770)</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	\$ 881,403	1
2	Discounts and Allowances for all Levels	31,327	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 912,730	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	71,439	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 71,439	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants	11,868	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,125	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	59,652	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	24,899	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 98,544	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	794	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 794	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a	<u>Miscellaneous</u>	265	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 265	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 1,083,772	30

2

Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	289,271	31
32	Health Care	553,548	32
33	General Administration	241,103	33
<b>B. Capital Expense</b>			
34	Ownership	229,871	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	27,259	35
36	Provider Participation Fee	41,610	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 1,382,662	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(298,890)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (298,890)	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 Sugar Creek Care Center

# 0047571

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	2,541	2,591	\$ 19,199	\$ 7.41	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,397	2,620	101,323	38.67	3
4	Licensed Practical Nurses	6,359	6,666	126,679	19.00	4
5	CNAs & Orderlies	18,351	18,876	162,055	8.59	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,733	1,745	18,207	10.43	9
10	Activity Assistants					10
11	Social Service Workers	1,135	1,135	17,071	15.04	11
12	Dietician					12
13	Food Service Supervisor	3,176	3,192	24,979	7.83	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,696	5,813	49,527	8.52	15
16	Dishwashers					16
17	Maintenance Workers	2,058	2,058	25,642	12.46	17
18	Housekeepers	6,615	6,840	54,995	8.04	18
19	Laundry	1,923	1,923	13,251	6.89	19
20	Administrator	2,032	2,032	53,823	26.49	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,930	1,954	16,655	8.52	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: <u>Care Plan Coordinator</u>		36	751	20.86	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	55,946	57,481	\$ 684,157 *	\$ 11.90	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	32	\$ 1,143	1,3	35
36	Medical Director	Monthly	6,000	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	510	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)	32	\$ 7,653		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>Donna Jenkins</u>	<u>Administrator</u>	<u>0</u>	\$ <u>53,823</u>	<u>Workers' Compensation Insurance</u>		\$ <u>15,770</u>		<u>IDPH License Fee</u>		\$ <u>150</u>		
				<u>Unemployment Compensation Insurance</u>		<u>41,039</u>		<u>Advertising: Employee Recruitment</u>		<u>78</u>		
				<u>FICA Taxes</u>		<u>50,429</u>		<u>Health Care Worker Background Check</u>		<u>1,090</u>		
				<u>Employee Health Insurance</u>		<u>5,585</u>		(Indicate # of checks performed <u>91</u> )				
				<u>Employee Meals</u>		<u>3,257</u>		<u>Patient Background Checks</u>				
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>				<u>Miscellaneous Lisenses &amp; Fees</u>		<u>246</u>		
				<u>Employee Retirement</u>		<u>317</u>		<u>Home Office Allocation</u>		<u>422</u>		
				<u>Employee Relations</u>		<u>2,786</u>						
<b>TOTAL (agree to Schedule V, line 17, col. 1)</b>			\$ <u>53,823</u>	<b>TOTAL (agree to Schedule V, line 22, col.8)</b>			\$ <u>119,183</u>	<b>TOTAL (agree to Sch. V, line 20, col. 8)</b>			\$ <u>1,986</u>	
<b>(List each licensed administrator separately.)</b>								<b>Less: Public Relations Expense</b>			( )	
								<b>Non-allowable advertising</b>			( )	
								<b>Yellow page advertising</b>			( )	
<b>B. Administrative - Other</b>												
<b>Description</b>			<b>Amount</b>	<b>Description</b>			<b>Amount</b>	<b>Description</b>			<b>Amount</b>	
<u>Management Fee Expense (fee eliminated in Col. 7)</u>			\$ <u>22,500</u>									
<b>TOTAL (agree to Schedule V, line 17, col. 3)</b>			\$ <u>22,500</u>	<b>E. Schedule of Non-Cash Compensation Paid to Owners or Employees</b>				<b>G. Schedule of Travel and Seminar**</b>				
<b>(Attach a copy of any management service agreement)</b>				<b>Description</b>			<b>Line #</b>	<b>Amount</b>	<b>Description</b>			<b>Amount</b>
<b>C. Professional Services</b>				<b>N/A</b>					<b>Out-of-State Travel</b>			\$
<b>Vendor/Payee</b>	<b>Type</b>	<b>Amount</b>										
<u>Altschuler, Melvoin &amp; Glasser, LLP</u>	<u>Accounting</u>	\$ <u>1,600</u>										
<u>Computer Services</u>	<u>Computer Services</u>	<u>3,235</u>										
<b>TOTAL (agree to Schedule V, line 19, column 3)</b>			\$ <u>4,835</u>	<b>TOTAL</b>			\$		<b>Seminar Expense</b>			
<b>(If total legal fees exceed \$5,000, attach copy of invoices.)</b>									<u>Home Office Allocation</u>			<u>2,588</u>
									<b>Less: Non-allowable expense</b>			<u>(2,271)</u>
									<b>Entertainment Expense</b>			( )
									<b>(agree to Sch. V, line 24, col. 8)</b>			
									<b>TOTAL</b>			\$ <u>317</u>

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

\*\*See instructions.

Sugar Creek Care Center  
Provider No: 0043596  
FYE: 12/31/2006

Schedule 21A

XIX. SUPPORT SCHEDULE  
C. Professional Services

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

4,835

Allocated from Home Office

Other Professional Fees

2,613

Legal

35

Other Professional Fees - PHO

1,076

Legal - PHO

33

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

8,592

**See Accountants' Compilation**

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

(See instructions.)

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sugar Creek Care Center# 0047571Report Period Beginning: 01/01/2006Ending: 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? Yes  
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. \$ 1,366 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. \$ 41,610  
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.
- (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. \$ 3,257 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,126
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Ginoli & Co The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit currently in progress
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees

**SEE ACCOUNTANTS' COMPILATION REPORT**