

Facility Name & ID Number Havana Health Care Center

0046086 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	20	Skilled (SNF)	20	7,300	1
2		Skilled Pediatric (SNF/PED)			2
3	78	Intermediate (ICF)	78	28,470	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	98	TOTALS	98	35,770	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			1,914	1,914	8
9	SNF/PED					9
10	ICF	17,859	5,205		23,064	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,859	5,205	1,914	24,978	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.83%

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

None (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 03/01/01

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

YES

Date 03/01/01

NO

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

YES

NO

If YES, enter number

of beds certified

20

and days of care provided

1,914

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: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number Havana Health Care Center # 0046086 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	151,219	25,297	2,283	178,799		178,799	2,090	180,889		1
2	Food Purchase		193,129		193,129		193,129	(148,789)	44,340		2
3	Housekeeping	77,183	12,263		89,446		89,446	24	89,470		3
4	Laundry	43,208	6,411		49,619		49,619	1	49,620		4
5	Heat and Other Utilities			107,969	107,969		107,969	357	108,326		5
6	Maintenance	37,223	9,979	16,194	63,396		63,396	2,912	66,308		6
7	Other (specify):* Home Off. Ben. All.							954	954		7
8	TOTAL General Services	308,833	247,079	126,446	682,358		682,358	(142,451)	539,907		8
	B. Health Care and Programs										
9	Medical Director			14,500	14,500		14,500		14,500		9
10	Nursing and Medical Records	920,570	45,767	1,200	967,537		967,537	4,811	972,348		10
10a	Therapy	56,330	227	29,115	85,672		85,672		85,672		10a
11	Activities	39,116	840	75	40,031		40,031		40,031		11
12	Social Services	23,286	80		23,366		23,366		23,366		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.							1,229	1,229		15
16	TOTAL Health Care and Programs	1,039,302	46,914	44,890	1,131,106		1,131,106	6,040	1,137,146		16
	C. General Administration										
17	Administrative	67,320			67,320		67,320	15,559	82,879		17
18	Directors Fees										18
19	Professional Services			9,187	9,187		9,187	4,224	13,411		19
20	Dues, Fees, Subscriptions & Promotions			11,593	11,593		11,593	103	11,696		20
21	Clerical & General Office Expenses	28,616	5,670	9,356	43,642		43,642	35,037	78,679		21
22	Employee Benefits & Payroll Taxes			190,636	190,636		190,636		190,636		22
23	Inservice Training & Education			193	193		193	408	601		23
24	Travel and Seminar			402	402		402	648	1,050		24
25	Other Admin. Staff Transportation			5,116	5,116		5,116	2,350	7,466		25
26	Insurance-Prop.Liab.Malpractice			18,642	18,642		18,642	957	19,599		26
27	Other (specify):* Home Off. Ben. All.							10,130	10,130		27
28	TOTAL General Administration	95,936	5,670	245,125	346,731		346,731	69,416	416,147		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,444,071	299,663	416,461	2,160,195		2,160,195	(66,995)	2,093,200		29

*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.

Facility Name & ID Number Havana Health Care Center

#0046086

Report Period Beginning:

01/01/2007

Ending:

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			79,329	79,329		79,329	9,084	88,413			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			259,790	259,790		259,790	3,903	263,693			32
33	Real Estate Taxes			84,619	84,619		84,619	817	85,436			33
34	Rent-Facility & Grounds							50	50			34
35	Rent-Equipment & Vehicles			10,091	10,091		10,091	658	10,749			35
36	Other (specify):*											36
37	TOTAL Ownership			433,829	433,829		433,829	14,512	448,341			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		54,298		54,298		54,298		54,298			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			53,655	53,655		53,655		53,655			42
43	Other (specify):* Non-allowable Cost	20,270	276	51,597	72,143		72,143	(72,143)				43
44	TOTAL Special Cost Centers	20,270	54,574	105,252	180,096		180,096	(72,143)	107,953			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,464,341	354,237	955,542	2,774,120		2,774,120	(124,626)	2,649,494			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.

Havana Health Care Center

ID# 0046086

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (18,901)	43	1
2	X-Rays-Part A	(6,370)	43	2
3	Resident Flower	(411)	43	3
4	Disallowed Special Events	(1,561)	43	4
5	Offset Disallowed Dues	(812)	20	5
6	Offset of Miscellaneous Income	(1,109)	10&21	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	(29,164)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Havana Health Care Center# 0046086

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	2,090	0	0	0	0	0	0	0	0	0	2,090	1
2	Food Purchase	(148,861)	72	0	0	0	0	0	0	0	0	0	(148,789)	2
3	Housekeeping	0	24	0	0	0	0	0	0	0	0	0	24	3
4	Laundry	0	1	0	0	0	0	0	0	0	0	0	1	4
5	Heat and Other Utilities	0	357	0	0	0	0	0	0	0	0	0	357	5
6	Maintenance	0	2,912	0	0	0	0	0	0	0	0	0	2,912	6
7	Other (specify):*	0	954	0	0	0	0	0	0	0	0	0	954	7
8	TOTAL General Services	(148,861)	6,410	0	0	0	0	0	0	0	0	0	(142,451)	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	5,527	0	0	0	0	0	0	0	0	0	5,527	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	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	1,229	0	0	0	0	0	0	0	0	0	1,229	15
16	TOTAL Health Care and Programs	0	6,756	0	0	0	0	0	0	0	0	0	6,756	16
	C. General Administration													
17	Administrative	0	15,559	0	0	0	0	0	0	0	0	0	15,559	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	4,224	0	0	0	0	0	0	0	0	0	4,224	19
20	Fees, Subscriptions & Promotions	(812)	0	915	0	0	0	0	0	0	0	0	103	20
21	Clerical & General Office Expenses	0	0	35,430	0	0	0	0	0	0	0	0	35,430	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	408	0	0	0	0	0	0	0	0	408	23
24	Travel and Seminar	0	0	648	0	0	0	0	0	0	0	0	648	24
25	Other Admin. Staff Transportation	0	0	2,350	0	0	0	0	0	0	0	0	2,350	25
26	Insurance-Prop.Liab.Malpractice	0	0	957	0	0	0	0	0	0	0	0	957	26
27	Other (specify):*	0	0	10,130	0	0	0	0	0	0	0	0	10,130	27
28	TOTAL General Administration	(812)	19,783	50,838	0	69,809	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(149,673)	32,949	50,838	0	(65,886)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Havana Health Care Center

0046086

Report Period Beginning:

01/01/2007

Ending:

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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 (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	6,603	0	2,481	0	0	0	0	0	0	0	0	9,084	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(409)	0	4,312	0	0	0	0	0	0	0	0	3,903	32
33	Real Estate Taxes	0	0	817	0	0	0	0	0	0	0	0	817	33
34	Rent-Facility & Grounds	0	0	50	0	0	0	0	0	0	0	0	50	34
35	Rent-Equipment & Vehicles	0	0	658	0	0	0	0	0	0	0	0	658	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	6,194	0	8,318	0	14,512	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):*	(72,143)	0	0	0	0	0	0	0	0	0	0	(72,143)	43
44	TOTAL Special Cost Centers	(72,143)	0	0	0	0	0	0	0	0	0	0	(72,143)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(215,622)	32,949	59,156	0	(123,517)	45							

Facility Name & ID Number

Havana Health Care Center

0046086

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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 6E		See Attached Sch 6E		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 2,090	\$ 2,090	1	
2	V	2 Food		Petersen Health Care, Inc.	100.00%	72	72	2	
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	24	24	3	
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	1	1	4	
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	357	357	5	
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	2,912	2,912	6	
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	954	954	7	
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	5,527	5,527	8	
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	0		9	
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,229	1,229	10	
11	V	17 Administrative		Petersen Health Care, Inc.	100.00%	15,559	15,559	11	
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	4,224	4,224	12	
13	V							13	
14	Total		\$			\$ 32,949	\$ *	32,949	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	20 Dues, Fees, Subs and Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 915	\$ 915	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	35,430	35,430	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	408	408	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	648	648	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	2,350	2,350	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	957	957	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	10,130	10,130	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	2,481	2,481	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	4,312	4,312	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	817	817	24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	50	50	25
26	V	35 Rent-Equipment and Vehicles		Petersen Health Care, Inc.	100.00%	658	658	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		\$			\$ 59,156	\$ * 59,156	39

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

Facility Name & ID Number

Havana Health Care Center

0046086

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Petersen	President	Administrative	100.00	See Schedule 7A	1.02	1.86	Salary	\$ 15,559	L17, C7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 15,559		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

Facility Name & ID Number Havana Health Care Center

0046086 Report Period Beginning: 01/01/2007 Ending: 2/31/2007

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 W. 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	Resident Days	0	66	\$ 110,171	\$ 109,587	29,733	\$ 2,090	1
2	2	Food	Resident Days	0	66	3,806	0	29,733	72	2
3	3	Housekeeping	Resident Days	0	66	1,250	0	29,733	24	3
4	4	Laundry	Resident Days	0	66	73	0	29,733	1	4
5	5	Utilities	Resident Days	0	66	18,812	0	29,733	357	5
6	6	Maintenance	Resident Days	0	66	153,468	113,063	29,733	2,912	6
7	7	Mgmt. Allocation of Benefits	Resident Days	0	66	50,271	0	29,733	954	7
8	10	Nursing and Medical Records	Resident Days	0	66	291,305	286,855	29,733	5,527	8
9	10A	Therapy	Resident Days	0	66	0	0	29,733	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	0	66	64,765	0	29,733	1,229	10
11	17	Administrative	Resident Days	0	66	820,116	820,116	29,733	15,559	11
12	19	Professional Services	Resident Days	0	66	222,628	0	29,733	4,224	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	0	66	48,243	0	29,733	915	13
14	21	Clerical and General Office	Resident Days	0	66	1,867,440	1,544,801	29,733	35,430	14
15	23	Inservice Training & Education	Resident Days	0	66	21,481	0	29,733	408	15
16	24	Travel and Seminar	Resident Days	0	66	34,177	0	29,733	648	16
17	25	Other Admin. Staff Transport.	Resident Days	0	66	123,847	0	29,733	2,350	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	0	66	50,427	0	29,733	957	18
19	27	Mgmt. Allocation of Benefits	Resident Days	0	66	533,953	0	29,733	10,130	19
20	30	Depreciation	Resident Days	0	66	130,767	0	29,733	2,481	20
21	32	Interest	Resident Days	0	66	227,295	0	29,733	4,312	21
22	33	Real Estate Taxes	Resident Days	0	66	43,090	0	29,733	817	22
23	34	Rent-Facility and Grounds	Resident Days	0	66	2,648	0	29,733	50	23
24	35	Rent-Equipment & Vehicles	Resident Days	0	66	34,690	0	29,733	658	24
25	TOTALS					\$ 4,854,723	\$ 2,874,422		\$ 92,105	25

Facility Name & ID Number

Havana Health Care Center

0046086

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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			
A. Directly Facility Related																		
Long-Term																		
1	LaSalle Bank		X	Mortgage	Varies	1/17/07	\$ 3,075,000	\$ 3,040,048	12/31/13	Varies	\$ 259,790	1						
2												2						
3							Offset Interest Income				(409)	3						
4							Home Office Allocation				4,312	4						
5												5						
Working Capital																		
6												6						
7												7						
8												8						
9	TOTAL Facility Related						\$ 3,075,000	\$ 3,040,048			\$ 263,693	9						
B. Non-Facility Related*																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 3,075,000	\$ 3,040,048			\$ 263,693	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.)

** 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 2006 report.		\$	72,000	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.)	2006	\$	77,119	2
3. Under or (over) accrual (line 2 minus line 1).		\$	5,119	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	79,500	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. Home Office Allocation			817	
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.		\$	85,436	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2002	65,743	8	
	2003	68,754	9	
	2004	67,250	10	
	2005	69,249	11	
	2006	77,119	12	
Accrual based on prior year tax bill.				
FOR BHF USE ONLY				
	13	FROM R. E. TAX STATEMENT FOR 2006	\$	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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Havana Health Care Center COUNTY Mason

FACILITY IDPH LICENSE NUMBER 0046086

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 2006 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 2006.

(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>005-1479000</u>	<u>Long-Term Care Facility</u>	\$ <u>77,097.00</u>	\$ <u>77,097.00</u>
2. <u>005-3910000</u>	<u>Land</u>	\$ <u>22.00</u>	\$ <u>22.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>77,119.00</u>	\$ <u>77,119.00</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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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 Havana Health Care Center

0046086

Report Period Beginning:

01/01/2007 Ending:

12/31/2007

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,208 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

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

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

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

N/A

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

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

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>418,945</u>	<u>2001</u>	<u>\$ 200,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	418,945		\$ 200,000	3

Facility Name & ID Number Havana Health Care Center

0046086

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

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	98	2001	1971	\$ 1,314,000	\$	35	\$ 37,543	\$ 37,543	\$ 244,029	4
5										5
6										6
7	Home Office Allocation			13,925			340	340		7
8										8
	Improvement Type**									
9	Roof		2001	22,650		20	1,133	1,133	7,364	9
10	Flooring		2001	5,890		20	295	295	1,917	10
11	Landscaping		2001	8,984		20	449	449	2,919	11
12	A/C Heating Unit		2001	2,046		20	102	102	787	12
13	Fencing		2002	758		20	38	38	209	13
14	Roofing		2002	500		20	25	25	138	14
15	Ceiling Tiles		2003	9,516		20	476	476	2,142	15
16	Doors		2004	2,305		20	115	115	403	16
17	Nursing Station		2004	8,100		20	405	405	1,418	17
18	Furnace		2004	3,382		20	169	169	592	18
19	Water Heater		2004	2,281		20	114	114	399	19
20	Concrete slab work		2005	3,919		20	196	196	490	20
21	Roofing		2006	2,991		20	150	150	225	21
22	Walk-In Freezer		2007	14,817		20	370	370	370	22
23										23
24										24
25										25
26	Building Booked				33,692			(33,692)		26
27	Building Improvement Booked				3,835			(3,835)		27
28										28
29										29
30										30
31	2007-Home Office Allocation-Building Improvements			932			55	55		31
32										32
33										33
34										34
35										35
36										36

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

See Page 12A, Line 70 for total

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

XI. OWNERSHIP COSTS (continued)

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

1	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)	\$ 1,416,996	\$ 37,527		\$ 41,975	\$ 4,448	\$ 263,402	70

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

Facility Name & ID Number Havana Health Care Center

0046086

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	\$ 406,915	\$ 39,524	\$ 40,692	\$ 1,168	7-10	\$ 291,185	71
72	Current Year Purchases	3,859	281	193	(88)	10	193	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			2,086	2,086			74
75	TOTALS	\$ 410,774	\$ 39,805	\$ 42,971	\$ 3,166		\$ 291,378	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Use	2001 Dodge Caravan	2001	\$ 46,577	\$	\$	\$	5	\$ 46,577	76
77	Facility Use	1999 Oldsmobile	2001	12,992				5	12,992	77
78	Facility Use	2001 Chevrolet	2003	10,002	1,152	2,000	848	5	9,000	78
79	Facility Use	1997 Jeep	2004	7,333	845	1,467	622	5	5,133	79
80	TOTALS			\$ 76,904	\$ 1,997	\$ 3,467	\$ 1,470		\$ 73,702	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,104,674	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 79,329	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 88,413	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 9,084	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 628,482	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		\$	\$	\$	86
87	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ _____			3
4	Additions				_____			4
5					_____			5
6		<u>Home Office Allocation</u>			<u>50</u>			6
7	TOTAL				\$ <u>50</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: _____*

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: \$ 10,749 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. _____/2008 \$ _____

13. _____/2009 \$ _____

14. _____/2010 \$ _____

* 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.

Havana Health Care Center

0046086

Period Beginning 01/01/2007

Period End 12/31/2007

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Copier	\$	5,536
Dishwasher		111
Maintenance Equipment		40
Nursing Equipment		4,404
Home Office Allocation		658
		<u>10,749</u>

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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	L. 10A, C. 3	2080 hrs	\$ 41,161	649	\$ 9,730		2,729	\$ 50,891	1
2	Licensed Speech and Language Development Therapist	L. 10A ,C. 3	54 hrs	1,766				54	1,766	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L. 10A, C. 3	211 hrs	13,403	1,292	19,385	227	1,503	33,015	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L. 39, C. 2	# of prescripts				54,298		54,298	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$ 56,330	1,941	\$ 29,115	\$ 54,525	4,286	\$ 139,970	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.

Facility Name & ID Number Havana Health Care Center

0046086

Report Period Beginning: 01/01/2007

Ending:

12/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,617,193	\$ 1,617,193	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	301,335	301,335	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	14,974	14,974	6
7	Other Prepaid Expenses	13,709	13,709	7
8	Accounts Receivable (owners or related parties)	1,003,862	1,003,862	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,951,073	\$ 2,951,073	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	208,984	200,000	13
14	Buildings, at Historical Cost	1,314,000	1,327,925	14
15	Leasehold Improvements, at Historical Cost	60,356	89,071	15
16	Equipment, at Historical Cost	503,487	487,678	16
17	Accumulated Depreciation (book methods)	(690,181)	(628,482)	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	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,396,646	\$ 1,476,192	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,347,719	\$ 4,427,265	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 241,123	\$ 241,123	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	120,446	120,446	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,768	2,768	31
32	Accrued Real Estate Taxes(Sch.IX-B)	79,500	79,500	32
33	Accrued Interest Payable	21,614	21,614	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	23,009	23,009	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 488,460	\$ 488,460	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	3,040,048	3,040,048	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,040,048	\$ 3,040,048	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,528,508	\$ 3,528,508	46
47	TOTAL EQUITY(page 18, line 24)	\$ 819,211	\$ 898,757	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,347,719	\$ 4,427,265	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 753,515	1
2	Restatements (describe):		2
3	Post Cost Report Audit Adjustments	(8,672)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 744,843	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	74,368	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 74,368	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)	\$ 819,211	24 *

* This must agree with page 17, line 47.

Havana Health Care Center
0046086
Period Beginning 01/01/2007
Period End 12/31/2007

Schedule 18A

XVI. Statement of Changes in Equity

Beginning Equity Restatements:

Post Cost Report Audit Adjustments

After filing the previous year's State of Illinois Financial and Statistical Report for Long-Term Care Facilities, an adjustment was made to the facility's financial records to properly state bad debt expense. Therefore, an adjustment to the current year's beginning equity is necessary to reconcile the previous year's cost report equity to the current year's equity per books. After this adjustment, cost report equity agrees to book equity on Schedule XVI.

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

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

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,287,279	1
2	Discounts and Allowances for all Levels	68,504	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,355,783	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	208,438	6
7	Oxygen	1,048	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 209,486	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	711	14
15	Telephone, Television and Radio	3,049	15
16	Rental of Facility Space		16
17	Sale of Drugs	93,696	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	32,900	20
21	Other Medical Services	3,195	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 133,551	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	409	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 409	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Jail Meals Revenue	148,150	28
28a	Miscellaneous Income	1,109	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 149,259	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,848,488	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	682,358	31
32	Health Care	1,131,106	32
33	General Administration	346,731	33
	B. Capital Expense		
34	Ownership	433,829	34
	C. Ancillary Expense		
35	Special Cost Centers	126,441	35
36	Provider Participation Fee	53,655	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,774,120	40
41	Income before Income Taxes (line 30 minus line 40)**	74,368	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 74,368	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. Facility is a division of a larger entity.

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

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

Facility Name & ID Number Havana Health Care Center

0046086

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

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	\$ 48,915	\$ 23.52	1
2	Assistant Director of Nursing	2,080	2,080	40,359	19.40	2
3	Registered Nurses	4,379	4,602	86,952	18.89	3
4	Licensed Practical Nurses	15,502	16,453	266,833	16.22	4
5	CNAs & Orderlies	42,924	44,998	444,183	9.87	5
6	CNA Trainees					6
7	Licensed Therapist	2,353	2,431	56,330	23.17	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,941	2,130	22,930	10.77	9
10	Activity Assistants	1,754	1,842	13,971	7.58	10
11	Social Service Workers	2,003	2,003	23,286	11.63	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	27,168	13.06	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,689	15,474	124,051	8.02	15
16	Dishwashers					16
17	Maintenance Workers	2,553	2,553	37,223	14.58	17
18	Housekeepers	8,732	8,886	77,183	8.69	18
19	Laundry	4,903	5,155	43,208	8.38	19
20	Administrator	2,080	2,080	67,320	32.37	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,080	2,080	28,616	13.76	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Sch. 20A</u>	2,882	2,897	55,813	19.27	33
34	TOTAL (lines 1 - 33)	115,015	119,824	\$ 1,464,341 *	\$ 12.22	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	43	\$ 2,283	1(3)	35
36	Medical Director	Monthly	14,500	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,200	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	43	\$ 17,983		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				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

Havana Health Care Center
0046086
Period Beginning 01/01/2007
Period End 12/31/2007

Schedule 20A

XVIII. Staffing and Salary Costs
Line 32-Other

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Marketing	761	761	20,270	26.64
Care Plan Coordinator	1,837	1,852	33,328	18.00
Transportation	284	284	2,215	7.80
Total Line 32-Other	2,882	2,897	55,813	19.27

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	
Susan Showalter	Administrator	0	\$ 67,320	Workers' Compensation Insurance	\$ 22,598	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance	25,435	Advertising: Employee Recruitment	663	
				FICA Taxes	108,499	Health Care Worker Background Check (Indicate # of checks performed)		
				Employee Health Insurance	29,508	Patient Background Checks	100 1,000	
				Employee Meals		Miscellaneous Dues & Subscriptions	860	
				Illinois Municipal Retirement Fund (IMRF)*		Home Office Allocation	915	
				Employee Relations	644	Misc. Licenses & Permits	702	
				Employee Retirement	3,131	LTC Solutions License	1,600	
				Smoking Cessation	821	IHCA Dues	4,778	
						Less: Public Relations Expense	(812)	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 67,320	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
					\$ 190,636		\$ 11,696	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 0				Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$				Seminar Expense	402
							Home Office Allocation	648
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 9,187	TOTAL		\$	TOTAL	\$ 1,050

* Attach copy of IMRF notifications

**See instructions.

Havana Health Care Center
0046086
Period Beginning 01/01/2007
Period End 12/31/2007

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		9,187
Non-allowable legal expense		-
(Real Estate Entity)		
	Legal	
	Accountants	
	Accountants	

Non-allowable Legal

Home Office Allocation

Pearl & Associates	27
Addy Bush & Assoc	14
Registered Agent Solutions	2
Heyl, Royster, Voelker & Allen	61
Duane Morris	95
Ginoli & Co.	966
RSM McGladrey	167
McGladrey & Pullen	255
Emdeon Business Services	66
Advanced Answers on Demand	1,791
Access 2 Go	135
Ivans	119
Kemper Technology	281
Adminastar Federal	35
LogmeIn	22
E-Health Data Solutions	176
Miscellaneous Vendors	12

Non-allowable Legal

Total (agree to Schedule V, line 19, column 8) 13,411

Facility Name & ID Number Havana Health Care Center# 0046086Report Period Beginning: 01/01/2007Ending: 12/31/2007**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? Yes
If YES, give association name and amount. IHCA-\$4,778
- (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 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ n/a Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 53,655
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. \$ Yes Has any meal income been offset against related costs? Yes Indicate the amount. \$ 148,861
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli & Company The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. Audit in progress
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, 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