

Facility Name & ID Number Kewanee Care Home

0026518 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	<u>27</u>	Skilled (SNF)	<u>27</u>	<u>9,855</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>57</u>	Intermediate (ICF)	<u>57</u>	<u>20,805</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>84</u>	TOTALS	<u>84</u>	<u>30,660</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			<u>2,917</u>	<u>2,917</u>	8
9	SNF/PED					9
10	ICF	<u>16,027</u>	<u>8,304</u>		<u>24,331</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>16,027</u>	<u>8,304</u>	<u>2,917</u>	<u>27,248</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.87%

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 6/1/76

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

YES

Date N/A

NO

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

YES

NO

If YES, enter number of beds certified 27 and days of care provided 2,917

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 Kewanee Care Home # 0026518 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	128,183	11,597		139,780		139,780	2,280	142,060		1
2	Food Purchase		139,223		139,223		139,223	(205)	139,018		2
3	Housekeeping	99,882	13,040		112,922		112,922	26	112,948		3
4	Laundry	30,353	11,783		42,136		42,136	2	42,138		4
5	Heat and Other Utilities			82,661	82,661		82,661	389	83,050		5
6	Maintenance	14,933	13,228	33,844	62,005		62,005	3,176	65,181		6
7	Other (specify):* Home Off. Ben. All.							1,040	1,040		7
8	TOTAL General Services	273,351	188,871	116,505	578,727		578,727	6,708	585,435		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	805,295	56,594	9,333	871,222		871,222	5,047	876,269		10
10a	Therapy	178,653	422		179,075		179,075		179,075		10a
11	Activities	55,765	170	176	56,111		56,111		56,111		11
12	Social Services	12,787			12,787		12,787		12,787		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.							1,340	1,340		15
16	TOTAL Health Care and Programs	1,052,500	57,186	21,509	1,131,195		1,131,195	6,387	1,137,582		16
	C. General Administration										
17	Administrative	53,245			53,245		53,245	16,974	70,219		17
18	Directors Fees										18
19	Professional Services			10,995	10,995		10,995	4,608	15,603		19
20	Dues, Fees, Subscriptions & Promotions			10,872	10,872		10,872	724	11,596		20
21	Clerical & General Office Expenses	51,926	5,494	20,889	78,309		78,309	37,832	116,141		21
22	Employee Benefits & Payroll Taxes			207,382	207,382		207,382		207,382		22
23	Inservice Training & Education			690	690		690	445	1,135		23
24	Travel and Seminar			460	460		460	707	1,167		24
25	Other Admin. Staff Transportation			6,746	6,746		6,746	2,563	9,309		25
26	Insurance-Prop.Liab.Malpractice			19,895	19,895		19,895	1,044	20,939		26
27	Other (specify):* Home Off. Ben. All.							11,051	11,051		27
28	TOTAL General Administration	105,171	5,494	277,929	388,594		388,594	75,948	464,542		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,431,022	251,551	415,943	2,098,516		2,098,516	89,043	2,187,559		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

Kewanee Care Home

#0026518

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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			67,451	67,451		67,451	27,936	95,387			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			482,469	482,469		482,469	132	482,601			32
33	Real Estate Taxes			32,544	32,544		32,544	(1,208)	31,336			33
34	Rent-Facility & Grounds							55	55			34
35	Rent-Equipment & Vehicles			4,984	4,984		4,984	718	5,702			35
36	Other (specify):*											36
37	TOTAL Ownership			587,448	587,448		587,448	27,633	615,081			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		86,474		86,474		86,474		86,474			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			45,990	45,990		45,990		45,990			42
43	Other (specify):* Non-allowable Cost		466	95,954	96,420		96,420	(96,420)				43
44	TOTAL Special Cost Centers		86,940	141,944	228,884		228,884	(96,420)	132,464			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,431,022	338,491	1,145,335	2,914,848		2,914,848	20,256	2,935,104			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.

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

0026518

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(284)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,565)	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	25,230	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(253)	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	(758)	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	(74,875)	43		24
25	Fund Raising, Advertising and Promotional	(3,862)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg. 5A	(18,853)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (80,220)		\$	30

BHF USE ONLY					
48		49		50	
				51	
					52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	100,476	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 100,476		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 20,256		37

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

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

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

Kewanee Care Home

ID# 0026518

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (4,518)	43	1
2	X-Rays-Part A	(2,566)	43	2
3	Resident Flowers	(1,244)	43	3
4	Disallowed special events	(1,779)	43	4
5	Offset Chamber of Commerce Dues	(275)	20	5
6	R.E. Tax on Non-Care Asset	(2,100)	33	6
7	Offset of Miscellaneous Income	(1,799)	43	7
8	Disallowed mortgage int. on non-care house	(4,572)	32	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	(18,853)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Kewanee Care Home# 0026518

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	2,280	0	0	0	0	0	0	0	0	0	2,280	1
2	Food Purchase	(284)	79	0	0	0	0	0	0	0	0	0	(205)	2
3	Housekeeping	0	26	0	0	0	0	0	0	0	0	0	26	3
4	Laundry	0	2	0	0	0	0	0	0	0	0	0	2	4
5	Heat and Other Utilities	0	389	0	0	0	0	0	0	0	0	0	389	5
6	Maintenance	0	3,176	0	0	0	0	0	0	0	0	0	3,176	6
7	Other (specify):*	0	1,040	0	0	0	0	0	0	0	0	0	1,040	7
8	TOTAL General Services	(284)	6,992	0	0	0	0	0	0	0	0	0	6,708	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	6,029	0	0	0	0	0	0	0	0	0	6,029	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	1,340	0	0	0	0	0	0	0	0	0	1,340	15
16	TOTAL Health Care and Programs	0	7,369	0	0	0	0	0	0	0	0	0	7,369	16
	C. General Administration													
17	Administrative	0	16,974	0	0	0	0	0	0	0	0	0	16,974	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	4,608	0	0	0	0	0	0	0	0	0	4,608	19
20	Fees, Subscriptions & Promotions	(275)	0	999	0	0	0	0	0	0	0	0	724	20
21	Clerical & General Office Expenses	0	0	38,649	0	0	0	0	0	0	0	0	38,649	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	445	0	0	0	0	0	0	0	0	445	23
24	Travel and Seminar	0	0	707	0	0	0	0	0	0	0	0	707	24
25	Other Admin. Staff Transportation	0	0	2,563	0	0	0	0	0	0	0	0	2,563	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,044	0	0	0	0	0	0	0	0	1,044	26
27	Other (specify):*	0	0	11,051	0	0	0	0	0	0	0	0	11,051	27
28	TOTAL General Administration	(275)	21,582	55,458	0	76,765	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(559)	35,943	55,458	0	90,842	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Kewanee Care Home# 0026518

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

	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	25,230	0	2,706	0	0	0	0	0	0	0	0	27,936	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,572)	0	4,704	0	0	0	0	0	0	0	0	132	32
33	Real Estate Taxes	(2,100)	0	892	0	0	0	0	0	0	0	0	(1,208)	33
34	Rent-Facility & Grounds	0	0	55	0	0	0	0	0	0	0	0	55	34
35	Rent-Equipment & Vehicles	0	0	718	0	0	0	0	0	0	0	0	718	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	18,558	0	9,075	0	27,633	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):*	(98,219)	0	0	0	0	0	0	0	0	0	0	(98,219)	43
44	TOTAL Special Cost Centers	(98,219)	0	0	0	0	0	0	0	0	0	0	(98,219)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(80,220)	35,943	64,533	0	20,256	45							

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark Petersen	100	See Attached Schedule 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%	\$ 2,280	\$ 2,280	1	
2	V	2 Food		Petersen Health Care, Inc.	100.00%	79	79	2	
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	26	26	3	
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	2	2	4	
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	389	389	5	
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	3,176	3,176	6	
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,040	1,040	7	
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	6,029	6,029	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%	1,340	1,340	10	
11	V	17 Administrative		Petersen Health Care, Inc.	100.00%	16,974	16,974	11	
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	4,608	4,608	12	
13	V							13	
14	Total		\$			\$ 35,943	\$ *	35,943	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%	\$ 999	\$	999	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	38,649		38,649	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	445		445	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	707		707	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	2,563		2,563	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	1,044		1,044	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	11,051		11,051	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	2,706		2,706	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	4,704		4,704	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	892		892	24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	55		55	25
26	V	35 Rent-Equipment and Vehicles		Petersen Health Care, Inc.	100.00%	718		718	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		\$			\$ 64,533	\$ *	64,533	39

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

Facility Name & ID Number

Kewanee Care Home

0026518

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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%	\$	\$	0	15	
16	V	2 Food		Petersen Health Care, Inc.	100.00%				16	
17	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%				17	
18	V	4 Laundry		Petersen Health Care, Inc.	100.00%				18	
19	V	5 Utilities		Petersen Health Care, Inc.	100.00%				19	
20	V	6 Maintenance		Petersen Health Care, Inc.	100.00%				20	
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%				21	
22	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%				22	
23	V	10A Therapy		Petersen Health Care, Inc.	100.00%				23	
24	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%				24	
25	V	17 Administrative		Petersen Health Care, Inc.	100.00%				25	
26	V	19 Professional Services		Petersen Health Care, Inc.	100.00%				26	
27	V	20 Dues, Fees, Subs and Prmotions		Petersen Health Care, Inc.	100.00%				27	
28	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%				28	
29	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%				29	
30	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%				30	
31	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%				31	
32	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%				32	
33	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%				33	
34	V	30 Depreciation		Petersen Health Care, Inc.	100.00%				34	
35	V	32 Interest		Petersen Health Care, Inc.	100.00%				35	
36	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%				36	
37	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%				37	
38	V	35 Rent-Equipment and Vehicles		Petersen Health Care, Inc.	100.00%				38	
39	Total		\$			\$	\$	0	\$ *	39

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

Facility Name & ID Number Kewanee Care Home

0026518

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

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		\$			\$	\$	15	
16	V							16	
17	V							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	Total		\$			\$	0	\$ *	39

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

Facility Name & ID Number

Kewanee Care Home

0026518

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	1.12	2.03	Salary	\$ 16,974	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	\$ 16,974		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 Kewanee Care Home# 0026518 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	1,316,550	66	\$ 110,171	\$ 109,587	27,248	\$ 2,280	1
2	2	Food	Resident Days	1,316,550	66	3,806	0	27,248	79	2
3	3	Housekeeping	Resident Days	1,316,550	66	1,250	0	27,248	26	3
4	4	Laundry	Resident Days	1,316,550	66	73	0	27,248	2	4
5	5	Utilities	Resident Days	1,316,550	66	18,812	0	27,248	389	5
6	6	Maintenance	Resident Days	1,316,550	66	153,468	113,063	27,248	3,176	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	50,271	0	27,248	1,040	7
8	10	Nursing and Medical Records	Resident Days	1,316,550	66	291,305	286,855	27,248	6,029	8
9	10A	Therapy	Resident Days	1,316,550	66	0	0	27,248	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	64,765	0	27,248	1,340	10
11	17	Administrative	Resident Days	1,316,550	66	820,116	820,116	27,248	16,974	11
12	19	Professional Services	Resident Days	1,316,550	66	222,628	0	27,248	4,608	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,316,550	66	48,243	0	27,248	999	13
14	21	Clerical and General Office	Resident Days	1,316,550	66	1,867,440	1,544,801	27,248	38,649	14
15	23	Inservice Training & Education	Resident Days	1,316,550	66	21,481	0	27,248	445	15
16	24	Travel and Seminar	Resident Days	1,316,550	66	34,177	0	27,248	707	16
17	25	Other Admin. Staff Transport.	Resident Days	1,316,550	66	123,847	0	27,248	2,563	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,316,550	66	50,427	0	27,248	1,044	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	533,953	0	27,248	11,051	19
20	30	Depreciation	Resident Days	1,316,550	66	130,767	0	27,248	2,706	20
21	32	Interest	Resident Days	1,316,550	66	227,295	0	27,248	4,704	21
22	33	Real Estate Taxes	Resident Days	1,316,550	66	43,090	0	27,248	892	22
23	34	Rent-Facility and Grounds	Resident Days	1,316,550	66	2,648	0	27,248	55	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,316,550	66	34,690	0	27,248	718	24
25	TOTALS					\$ 4,854,723	\$ 2,874,422		\$ 100,476	25

Facility Name & ID Number

Kewanee Care Home

0026518

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	\$ 5,775,000	\$ 5,709,358	12/31/13	Varies	\$ 477,714	1						
2	Community State Bank		X	Van Purchase	\$722.00	10/23/02	43,315		9/23/07	0.0850	183	2						
3												3						
4									Home Office Allocation		4,704	4						
5												5						
	Working Capital																	
6												6						
7												7						
8												8						
9	TOTAL Facility Related				\$722.00		\$ 5,818,315	\$ 5,709,358			\$ 482,601	9						
	B. Non-Facility Related*																	
10	Associated Bank		X	Mortgage on House	\$879.00	11/16/05	70,500	60,358	10/16/15	0.0850	4,572	10						
11												11						
12									Disallowed interest		(4,572)	12						
13												13						
14	TOTAL Non-Facility Related				\$879.00		\$ 70,500	\$ 60,358				14						
15	TOTALS (line 9+line14)						\$ 5,888,815	\$ 5,769,716			\$ 482,601	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.		\$	22,500	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	\$	27,044	2
3. Under or (over) accrual (line 2 minus line 1).		\$	4,544	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	28,000	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.			(2,100)	
			892	
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.		\$	31,336	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002	9,670	8
	2003	21,080	9
	2004	22,615	10
	2005	22,716	11
	2006	27,044	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 Kewanee Care Home COUNTY Henry

FACILITY IDPH LICENSE NUMBER 0026518

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 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>25-05-281-017</u>	<u>901 W. Mill St.</u>	\$ <u>104.00</u>	\$ <u>104.00</u>
2. <u>25-04-151-009</u>	<u>144 Junior Ave.</u>	\$ <u>24,762.00</u>	\$ <u>24,762.00</u>
3. <u>25-04-152-001</u>	<u>821 Dewey Ave.</u>	\$ <u>79.00</u>	\$ <u>79.00</u>
4. <u>25-04-451-014</u>	<u>529 Whitney Avenue</u>	\$ <u>2,100.00</u>	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>27,045.00</u>	\$ <u>24,945.00</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? X YES NO **NON-CARE PROPERTY IS DISALLOWED ON PAGE 10**

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 Kewanee Care Home

0026518

Report Period Beginning:

01/01/2007 Ending:

12/31/2007

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 12,548 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>42,000</u>	<u>1976</u>	<u>\$ 25,000</u>	<u>1</u>
2	<u>Facility</u>	<u>11,250</u>	<u>1992</u>	<u>25,621</u>	<u>2</u>
3	TOTALS	53,250		\$ 50,621	3

Facility Name & ID Number Kewanee Care Home

0026518

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	65	1976		\$ 381,128	\$	30	\$	\$	\$ 381,128	4
5	11	1998	1998	753,696		40	18,842	18,842	181,053	5
6	8	2002	2002	672,751		40	16,819	16,819	58,865	6
7	Home Office Allocation		2007	15,191			371	371		7
8										8
	Improvement Type**									
9	Various		1984	14,365		30	479	479	11,050	9
10	Various		1985	7,400		10			7,400	10
11	Various		1987	10,278		10-15			10,278	11
12	Various		1988	14,958		10-15			14,958	12
13	Various		1989	1,900		15			1,900	13
14	Various		1991	8,793		15			8,793	14
15	Various		1992	16,898		12			16,898	15
16	Various		1993	4,962		10			4,962	16
17	Various		1994	22,158		15	1,477	1,477	19,325	17
18	Various		1995	31,243		20	1,562	1,562	19,562	18
19	Tile Flooring		1996	1,083		20	54	54	639	19
20	Curtains Custom		1996	1,275		20	64	64	747	20
21	Emergency Light		1996	304		20	15	15	175	21
22	Fire Alarm		1996	2,099		20	105	105	1,225	22
23	Tile Flooring		1996	1,287		20	64	64	741	23
24	Boiler		1996	2,996		20	150	150	1,688	24
25	Water Heater Repair		1996	1,010		20	51	51	608	25
26	Ceiling Repairs		1996	2,117		20	106	106	1,263	26
27	Piping Repairs		1996	855		20	43	43	512	27
28	Fire Alarm		1996	1,331		20	67	67	748	28
29	Fire System		1996	1,564		20	78	78	891	29
30	Landscaping		1996	9,815		20	491	491	5,687	30
31	Landscaping		1996	1,986		20	99	99	1,122	31
32	Chrome Door Knob		1996	72		20	4	4	47	32
33	Emergency Light		1996	182		20	9	9	108	33
34	Painting		1996	672		20	34	34	402	34
35	Floor Tile		1997	8,472		20	424	424	4,593	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.

Facility Name & ID Number Kewanee Care Home

0026518

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Storage Shed	1997	\$ 10,177	\$	20	\$ 509	\$ 509	\$ 5,302	37
38	Windows	1997	5,136		20	257	257	2,699	38
39	Ceiling Repairs	1997	8,291		20	415	415	4,288	39
40	Landscaping	1997	8,085		20	404	404	4,141	40
41	Landscaping	1997	1,298		20	65	65	666	41
42	Whirlpool	1997	9,343		20	467	467	4,709	42
43	Boiler	1997	3,000		20	150	150	1,525	43
44	Wing Additions	1997	3,700		20	185	185	1,865	44
45	Attic Piping	1997	3,318		20	166	166	1,729	45
46	Compressor	1997	809		20	40	40	403	46
47	Fire Alarm	1997	2,338		20	117	117	1,249	47
48	Code Alert Receiver	1997	1,863		20	93	93	992	48
49	New sign	1998	7,304		20	365	365	6,205	49
50	Landscaping	1998	21,500		20	1,075	1,075	10,392	50
51	Duct Work-New Wing	1999	1,494		20	75	75	637	51
52	Tiling	1999	914		20	46	46	391	52
53	Water Heater	1999	2,835		20	142	142	1,207	53
54	Water Heater	1999	3,766		20	188	188	1,598	54
55	Cubicle Partitions	1999	701		20	35	35	297	55
56	Beauty Salon	2000	943		20	47	47	353	56
57	Tile Flooring	2000	10,294		20	515	515	3,862	57
58	Lot/House Razed	2000	21,237		20	1,062	1,062	7,965	58
59	Concrete	2001	900		15	60	60	420	59
60	Landscaping	2001	1,045		15	70	70	491	60
61	Lighting	2001	3,438		39	88	88	616	61
62	Blinds/Curtains	2001	9,500		7	1,358	1,358	9,500	62
63	Landscaping	2002	24,614		15	1,641	1,641	9,025	63
64	Landscaping	2002	4,075		15	272	272	1,496	64
65	Architectural	2002	21,778		20	1,089	1,089	5,989	65
66	Carpeting	2002	2,551		20	128	128	704	66
67	Fire System	2002	4,677		20	234	234	1,287	67
68	Landscaping	2003	4,899		15	327	327	1,471	68
69	Simplex Time Clock	2004	3,198		10	320	320	1,120	69
70	TOTAL (lines 4 thru 69)		\$ 2,201,862	\$		\$ 53,413	\$ 53,413	\$ 851,962	70

**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	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,201,862	\$		\$ 53,413	\$ 53,413	\$ 851,962	1
2	Air Conditioner	2004	2,700		10	270	270	945	2
3									3
4	Side walks	2005	2,065		15	138	138	414	4
5	Floor covering	2005	13,891		7	1,984	1,984	5,952	5
6	Flooring	2006	28,527		25	1,141	1,141	1,712	6
7	Driveway	2007	7,101		15	237	237	237	7
8	Boiler	2007	2,895		10	145	145	145	8
9									9
10									10
11									11
12									12
13									13
14									14
15	Building Booked			19,325			(19,325)		15
16	Building Improvement Booked			31,944			(31,944)		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	2007-Home Office Allocation-Building Improvements		1,016			60	60		29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,260,057	\$ 51,269		\$ 57,388	\$ 6,119	\$ 861,367	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 310,765	\$ 12,246	\$ 31,077	\$ 18,831	7 - 10	\$ 202,415	71
72	Current Year Purchases	5,554	386	278	(108)	10	278	72
73	Fully Depreciated Assets	107,989					107,989	73
74	Home Office Allocation			3,137	3,137			74
75	TOTALS	\$ 424,308	\$ 12,632	\$ 34,492	\$ 21,860		\$ 310,682	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	1997 Dodge Caravan	1998	\$ 32,369	\$ 1,775	\$	\$ (1,775)	4	\$ 32,369	76
77	Facility	2000 Town & Country	2002	35,088	1,775	3,507	1,732	5	35,088	77
78										78
79										79
80	TOTALS			\$ 67,457	\$ 3,550	\$ 3,507	\$ (43)		\$ 67,457	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)	\$ 2,802,443	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 67,451	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 95,387	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 27,936	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,239,506	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	November 2005 - House	\$ 70,500	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 70,500	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	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>55</u>			6
7	TOTAL			\$ <u>55</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: \$ 5,702 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.

Kewanee Care Home

0026518

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	\$ 2,550
Dishwasher	649
Medical Equipment	1,785
Home Office Allocation	718
	<u>5,702</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	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)	877	hrs	\$ 33,245		\$	\$	877	\$ 33,245	1
2	Licensed Speech and Language Development Therapist			hrs							2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10A(2)&(3)	6363	hrs	145,408			422	6,363	145,830	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39(2)		# of prescripts				86,474		86,474	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				\$ 178,653		\$	\$ 86,896	7,240	\$ 265,549	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.

Kewanee Care Home

0026518

Period Beginning 01/01/2007

Period End 12/31/2007

Schedule 17A

XV. Balance Sheet

Current Assets

Line 9- Other

	Operating	After Consolidatio
Security Deposit	870	870
Employee Education Loans	1,584	1,584
Employee Advances	(25)	(25)
Total Line 9 Other Current Assets	<u>2,429</u>	<u>2,429</u>

XV. Balance Sheet

Current Liabilities

Line 36 - Other Current Liabilities

	Operating	After Consolidatio
Fica W/H & Employer Fica	9,628	9,628
Federal Withholding	11,155	11,155
State Withholding II	3,606	3,606
Wage Garnishment	814	814
Tuition Grant	(1,362)	(1,362)
Other Withholdings	165	165
401-K Withholding	4,182	4,182
Other Withholdings	(687)	(687)
Education Loans	807	807
Life Insurance Withholding	(37)	(37)
Total Line 36 Other Current Liabilities	<u>28,271</u>	<u>28,271</u>

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,756,839	1
2	Restatements (describe):		2
3	Post Cost Report Audit Adjustments	(16,886)	3
4	Rounding	(2)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,739,951	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	553,354	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)	\$ 553,354	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)	\$ 5,293,305	24 *

* This must agree with page 17, line 47.

Kewanee Care Home

0026518

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	\$ 2,850,242	1
2	Discounts and Allowances for all Levels	231,346	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,081,588	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	319	5
6	Therapy	220,654	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 220,973	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	284	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	153,679	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	2,787	20
21	Other Medical Services	6,497	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 163,247	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	1,800	28
28a	Transportation Revenue	594	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,394	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,468,202	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	578,727	31
32	Health Care	1,131,195	32
33	General Administration	388,594	33
	B. Capital Expense		
34	Ownership	587,448	34
	C. Ancillary Expense		
35	Special Cost Centers	182,894	35
36	Provider Participation Fee	45,990	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,914,848	40
41	Income before Income Taxes (line 30 minus line 40)**	553,354	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 553,354	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.

Kewanee Care Home

0026518

Period Beginning 01/01/2007

Period End 12/31/2007

Schedule 19A

XVII. INCOME STATEMENT

Line 28a - Other revenue

Total

-
=====

Facility Name & ID Number Kewanee Care Home

0026518

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	2,072	2,192	\$ 55,396	\$ 25.27	1
2	Assistant Director of Nursing	851	851	17,566	20.64	2
3	Registered Nurses	3,450	3,450	65,960	19.12	3
4	Licensed Practical Nurses	15,070	15,612	244,759	15.68	4
5	CNAs & Orderlies	41,594	42,716	400,101	9.37	5
6	CNA Trainees					6
7	Licensed Therapist	7,140	7,240	178,653	24.68	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,004	2,012	21,230	10.55	9
10	Activity Assistants	2,125	2,273	17,229	7.58	10
11	Social Service Workers	1,077	1,077	12,787	11.87	11
12	Dietician					12
13	Food Service Supervisor	2,003	2,003	20,610	10.29	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,651	14,052	107,573	7.66	15
16	Dishwashers					16
17	Maintenance Workers	1,124	1,197	14,933	12.48	17
18	Housekeepers	12,519	12,855	99,882	7.77	18
19	Laundry	3,886	4,063	30,353	7.47	19
20	Administrator	2,080	2,080	53,245	25.60	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	4,117	4,202	51,926	12.36	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: Care Plan Coord.	1,013	1,013	21,513	21.24	32
33	Other(specify) <u>Transportation</u>	2,002	2,048	17,306	8.45	33
34	TOTAL (lines 1 - 33)	117,778	120,936	\$ 1,431,022 *	\$ 11.83	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant			35
36	Medical Director	Monthly 12,000	9(3)	36
37	Medical Records Consultant	Monthly 720	10(3)	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)	\$ 13,920		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

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

0026518

Report Period Beginning: **01/01/2007**

Ending: **12/31/2007**

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			
Brent Morgan	Administrator	0	\$ 45,715	Workers' Compensation Insurance	\$ 26,697	IDPH License Fee	\$ 1,990			
Nat Smith	Administrator	0	7,530	Unemployment Compensation Insurance	25,746	Advertising: Employee Recruitment	298			
				FICA Taxes	106,055	Health Care Worker Background Check (Indicate # of checks performed)				
				Employee Health Insurance	37,998	Patient Background Checks	97			
				Employee Meals		Miscellaneous Licenses & Fees	961			
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Dues & Subscriptions	275			
				Employee Relations	8,122	Home Office Allocation	999			
				Employee Retirement	2,764	LTC Solutions License	1,600			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 53,245	TOTAL (agree to Schedule V, line 22, col.8)			\$ 207,382	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 11,596
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)			\$	TOTAL			Seminar Expense	460		
C. Professional Services										
Vendor/Payee	Type		Amount							
Insight Communications	Computer Services		\$ 1,390				Home Office Allocation	707		
E-Health Data Solutions	Computer Services		2,025				Entertainment Expense (agree to Sch. V, line 24, col. 8)			
RSM McGladrey	Accounting Services		6,080				TOTAL	\$ 1,167		
Senior Housing Consultants	Feasibility Study		1,500							
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 10,995							

* Attach copy of IMRF notifications

**See instructions.

Kewanee Care Home

0026518

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)		10,995
------------------------------------------------	--	--------

Home Office Allocation

Pearl & Associates	Legal	30
Addy Bush & Assoc	Legal	15
Registered Agent Solutions	Legal	3
Heyl, Royster, Voelker & Allen	Legal	67
Duane Morris	Legal	103
Ginoli & Co.	Accountants	1,053
RSM McGladrey	Accountants	182
McGladrey & Pullen	Accountants	278
Emdeon Business Services	Computer Services	72
Advanced Answers on Demand	Computer Services	1,954
Access 2 Go	Computer Services	147
Ivans	Computer Services	129
Kemper Technology	Computer Services	306
Adminastar Federal	Computer Services	38
Logmeln	Computer Services	24
E-Health Data Solutions	Computer Services	192
Miscellaneous Vendors	Miscellaneous	15

Non-allowable Legal

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

15,603

Facility Name & ID Number Kewanee Care Home# 0026518Report 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. \$ 10,298 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. \$ 45,990
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (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. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 284
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? Adequate records have been maintained.
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli & Co. The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? 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