

Facility Name & ID Number Newman Rehabilitation & Health Care Center

0047506 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	60	Skilled (SNF)	60	21,900	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	60	TOTALS	60	21,900	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	11,679	5,477	1,344	18,500	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,679	5,477	1,344	18,500	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.47%

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 10/1/2005

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

YES

Date 10/1/2005

NO

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

YES

NO

If YES, enter number of beds certified 60 and days of care provided 1,344

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 Newman Rehabilitation & Health Care Cente # 0047506 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	98,034	9,450	368	107,852		107,852	3,725	111,577		1
2	Food Purchase		92,211		92,211		92,211	(747)	91,464		2
3	Housekeeping	73,140	11,756		84,896		84,896	18	84,914		3
4	Laundry	13,953	10,836		24,789		24,789	1	24,790		4
5	Heat and Other Utilities			60,987	60,987		60,987	264	61,251		5
6	Maintenance	32,639	9,427	22,660	64,726		64,726	2,171	66,897		6
7	Other (specify):* Home Off. Ben. All.							2,522	2,522		7
8	TOTAL General Services	217,766	133,680	84,015	435,461		435,461	7,954	443,415		8
	B. Health Care and Programs										
9	Medical Director			11,000	11,000		11,000		11,000		9
10	Nursing and Medical Records	613,451	27,650	12,225	653,326		653,326	6,651	659,977		10
10a	Therapy			261,714	261,714		261,714		261,714		10a
11	Activities	31,746	287	2,845	34,878		34,878		34,878		11
12	Social Services	22,701			22,701		22,701		22,701		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.							3,038	3,038		15
16	TOTAL Health Care and Programs	667,898	27,937	287,784	983,619		983,619	9,689	993,308		16
	C. General Administration										
17	Administrative	33,590		60,000	93,590		93,590	(39,583)	54,007		17
18	Directors Fees										18
19	Professional Services			8,105	8,105		8,105	5,697	13,802		19
20	Dues, Fees, Subscriptions & Promotions			6,489	6,489		6,489	736	7,225		20
21	Clerical & General Office Expenses	24,423	3,380	7,753	35,556		35,556	28,633	64,189		21
22	Employee Benefits & Payroll Taxes			147,006	147,006		147,006		147,006		22
23	Inservice Training & Education							302	302		23
24	Travel and Seminar			745	745		745	481	1,226		24
25	Other Admin. Staff Transportation			2,824	2,824		2,824	3,130	5,954		25
26	Insurance-Prop.Liab.Malpractice			15,084	15,084		15,084	709	15,793		26
27	Other (specify):* Home Off. Ben. All.							14,920	14,920		27
28	TOTAL General Administration	58,013	3,380	248,006	309,399		309,399	15,025	324,424		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	943,677	164,997	619,805	1,728,479		1,728,479	32,668	1,761,147		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

Newman Rehabilitation & Health Care Center

#0047506

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			9,589	9,589		9,589	1,952	11,541			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			36,028	36,028		36,028	41,776	77,804			32
33	Real Estate Taxes			20,931	20,931		20,931	605	21,536			33
34	Rent-Facility & Grounds			378,326	378,326		378,326	37	378,363			34
35	Rent-Equipment & Vehicles			2,235	2,235		2,235	487	2,722			35
36	Other (specify):*											36
37	TOTAL Ownership			447,109	447,109		447,109	44,857	491,966			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		22,485		22,485		22,485		22,485			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			32,850	32,850		32,850		32,850			42
43	Other (specify):* Non-allowable Cost		129	21,354	21,483		21,483	(21,483)				43
44	TOTAL Special Cost Centers		22,614	54,204	76,818		76,818	(21,483)	55,335			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	943,677	187,611	1,121,118	2,252,406		2,252,406	56,042	2,308,448			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.

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	(800)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,604)	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	(935)	30		9
10	Interest and Other Investment Income	(635)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(561)	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	(135)	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	(10,631)	43		24
25	Fund Raising, Advertising and Promotional	(2,677)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule <u>See Pg. 5A</u>	(4,983)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (23,961)		\$	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)	80,003	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 80,003		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 56,042		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

Newman Rehabilitation & Health Care Center

ID# 0047506

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (1,901)	43	1
2	X-Rays-Part A	(1,909)	43	2
3	Resident Flower	(517)	10	3
4	Disallowed Special Events	(548)	43	4
5	Offset Miscellaneous Office Supplies Revenue	(108)	21	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(4,983)		49

STATE OF ILLINOIS

Summary A

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

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	1,548	0	2,177	0	0	0	0	0	0	0	3,725	1
2	Food Purchase	(800)	53	0	0	0	0	0	0	0	0	0	(747)	2
3	Housekeeping	0	18	0	0	0	0	0	0	0	0	0	18	3
4	Laundry	0	1	0	0	0	0	0	0	0	0	0	1	4
5	Heat and Other Utilities	0	264	0	0	0	0	0	0	0	0	0	264	5
6	Maintenance	0	2,156	0	15	0	0	0	0	0	0	0	2,171	6
7	Other (specify):*	0	706	0	1,816	0	0	0	0	0	0	0	2,522	7
8	TOTAL General Services	(800)	4,746	0	4,008	0	7,954	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	(517)	4,093	0	2,558	0	0	0	0	0	0	0	6,134	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	910	0	2,128	0	0	0	0	0	0	0	3,038	15
16	TOTAL Health Care and Programs	(517)	5,003	0	4,686	0	9,172	16						
	C. General Administration													
17	Administrative	0	(48,476)	0	8,893	0	0	0	0	0	0	0	(39,583)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	3,128	0	2,569	0	0	0	0	0	0	0	5,697	19
20	Fees, Subscriptions & Promotions	0	0	678	58	0	0	0	0	0	0	0	736	20
21	Clerical & General Office Expenses	(108)	0	26,241	2,500	0	0	0	0	0	0	0	28,633	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	302	0	0	0	0	0	0	0	0	302	23
24	Travel and Seminar	0	0	480	1	0	0	0	0	0	0	0	481	24
25	Other Admin. Staff Transportation	0	0	1,740	1,390	0	0	0	0	0	0	0	3,130	25
26	Insurance-Prop.Liab.Malpractice	0	0	709	0	0	0	0	0	0	0	0	709	26
27	Other (specify):*	0	0	7,503	7,417	0	0	0	0	0	0	0	14,920	27
28	TOTAL General Administration	(108)	(45,348)	37,653	22,828	0	15,025	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(1,425)	(35,599)	37,653	31,522	0	32,151	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Newman Rehabilitation & Health Care Center # 0047506 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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(935)	0	1,837	1,050	0	0	0	0	0	0	0	1,952	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(635)	0	3,194	39,217	0	0	0	0	0	0	0	41,776	32
33	Real Estate Taxes	0	0	605	0	0	0	0	0	0	0	0	605	33
34	Rent-Facility & Grounds	0	0	37	0	0	0	0	0	0	0	0	37	34
35	Rent-Equipment & Vehicles	0	0	487	0	0	0	0	0	0	0	0	487	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(1,570)	0	6,160	40,267	0	44,857	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):*	(20,966)	0	0	0	0	0	0	0	0	0	0	(20,966)	43
44	TOTAL Special Cost Centers	(20,966)	0	0	0	0	0	0	0	0	0	0	(20,966)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(23,961)	(35,599)	43,813	71,789	0	56,042	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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 1,548	\$ 1,548	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	53	53	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	18	18	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	1	1	4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	264	264	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	2,156	2,156	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	706	706	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	4,093	4,093	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%	910	910	10
11	V	17 Administrative	60,000	Petersen Health Care, Inc.	100.00%	11,524	(48,476)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	3,128	3,128	12
13	V							13
14	Total		\$ 60,000			\$ 24,401	\$ * (35,599)	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%	\$ 678	\$	678	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	26,241		26,241	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	302		302	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	480		480	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	1,740		1,740	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	709		709	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	7,503		7,503	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	1,837		1,837	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	3,194		3,194	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	605		605	24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	37		37	25
26	V	35 Rent-Equipment and Vehicles		Petersen Health Care, Inc.	100.00%	487		487	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 43,813	\$ *	43,813	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1 Dietary	\$	Petersen Health Operations, LLC	100.00%	\$ 2,177	\$	2,177	15
16	V	2 Food		Petersen Health Operations, LLC	100.00%	0		0	16
17	V	3 Housekeeping		Petersen Health Operations, LLC	100.00%	0		0	17
18	V	4 Laundry		Petersen Health Operations, LLC	100.00%	0		0	18
19	V	5 Utilities		Petersen Health Operations, LLC	100.00%	0		0	19
20	V	6 Maintenance		Petersen Health Operations, LLC	100.00%	15		15	20
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	1,816		1,816	21
22	V	10 Nursing and Medical Records		Petersen Health Operations, LLC	100.00%	2,558		2,558	22
23	V	10A Therapy		Petersen Health Operations, LLC	100.00%	0		0	23
24	V	15 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	2,128		2,128	24
25	V	17 Administrative		Petersen Health Operations, LLC	100.00%	8,893		8,893	25
26	V	19 Professional Services		Petersen Health Operations, LLC	100.00%	2,569		2,569	26
27	V	20 Dues, Fees, Subs and Promotions		Petersen Health Operations, LLC	100.00%	58		58	27
28	V	21 Clerical and General Office		Petersen Health Operations, LLC	100.00%	2,500		2,500	28
29	V	23 Inservice Training and Education		Petersen Health Operations, LLC	100.00%	0		0	29
30	V	24 Travel and Seminar		Petersen Health Operations, LLC	100.00%	1		1	30
31	V	25 Other Admin. Staff Transportation		Petersen Health Operations, LLC	100.00%	1,390		1,390	31
32	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Operations, LLC	100.00%	0		0	32
33	V	27 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	7,417		7,417	33
34	V	30 Depreciation		Petersen Health Operations, LLC	100.00%	1,050		1,050	34
35	V	32 Interest		Petersen Health Operations, LLC	100.00%	39,217		39,217	35
36	V	33 Real Estate Taxes		Petersen Health Operations, LLC	100.00%	0		0	36
37	V	34 Rent-Facility and Grounds		Petersen Health Operations, LLC	100.00%	0		0	37
38	V	35 Rent-Equipment and Vehicles		Petersen Health Operations, LLC	100.00%	0		0	38
39	Total		\$			\$ 71,789	\$ *	71,789	39

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

Facility Name & ID Number Newman Rehabilitation & Health Care Cent # 0047506 Report Period Beginning: 01/01/2007 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	0.76	1.38	Salary	\$ 11,524	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	\$ 11,524		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 Newman Rehabilitation & Health Care Center# 0047506

Report Period Beginning:

01/01/2007Ending: 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	18,500	\$ 1,548	1
2	2	Food	Resident Days	1,316,550	66	3,806	0	18,500	53	2
3	3	Housekeeping	Resident Days	1,316,550	66	1,250	0	18,500	18	3
4	4	Laundry	Resident Days	1,316,550	66	73	0	18,500	1	4
5	5	Utilities	Resident Days	1,316,550	66	18,812	0	18,500	264	5
6	6	Maintenance	Resident Days	1,316,550	66	153,468	113,063	18,500	2,156	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	50,271	0	18,500	706	7
8	10	Nursing and Medical Records	Resident Days	1,316,550	66	291,305	286,855	18,500	4,093	8
9	10A	Therapy	Resident Days	1,316,550	66	0	0	18,500	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	64,765	0	18,500	910	10
11	17	Administrative	Resident Days	1,316,550	66	820,116	820,116	18,500	11,524	11
12	19	Professional Services	Resident Days	1,316,550	66	222,628	0	18,500	3,128	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,316,550	66	48,243	0	18,500	678	13
14	21	Clerical and General Office	Resident Days	1,316,550	66	1,867,440	1,544,801	18,500	26,241	14
15	23	Inservice Training & Education	Resident Days	1,316,550	66	21,481	0	18,500	302	15
16	24	Travel and Seminar	Resident Days	1,316,550	66	34,177	0	18,500	480	16
17	25	Other Admin. Staff Transport.	Resident Days	1,316,550	66	123,847	0	18,500	1,740	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,316,550	66	50,427	0	18,500	709	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	533,953	0	18,500	7,503	19
20	30	Depreciation	Resident Days	1,316,550	66	130,767	0	18,500	1,837	20
21	32	Interest	Resident Days	1,316,550	66	227,295	0	18,500	3,194	21
22	33	Real Estate Taxes	Resident Days	1,316,550	66	43,090	0	18,500	605	22
23	34	Rent-Facility and Grounds	Resident Days	1,316,550	66	2,648	0	18,500	37	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,316,550	66	34,690	0	18,500	487	24
25	TOTALS					\$ 4,854,723	\$ 2,874,422		\$ 68,214	25

Facility Name & ID Number Newman Rehabilitation & Health Care Center

0047506

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 Operations, LLC
 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	440,525	23	\$ 51,832	\$ 51,832	18,500	\$ 2,177	1
2	2	Food	Resident Days	440,525	23			18,500		2
3	3	Housekeeping	Resident Days	440,525	23			18,500		3
4	4	Laundry	Resident Days	440,525	23			18,500		4
5	5	Utilities	Resident Days	440,525	23			18,500		5
6	6	Maintenance	Resident Days	440,525	23	358		18,500	15	6
7	7	Mgmt. Allocation of Benefits	Resident Days	440,525	23	43,237		18,500	1,816	7
8	10	Nursing and Medical Records	Resident Days	440,525	23	60,910	60,761	18,500	2,558	8
9	10A	Therapy	Resident Days	440,525	23			18,500		9
10	15	Mgmt. Allocation of Benefits	Resident Days	440,525	23	50,681		18,500	2,128	10
11	17	Administrative	Resident Days	440,525	23	211,751	211,751	18,500	8,893	11
12	19	Professional Services	Resident Days	440,525	23	61,162		18,500	2,569	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	440,525	23	1,373		18,500	58	13
14	21	Clerical and General Office	Resident Days	440,525	23	59,529		18,500	2,500	14
15	23	Inservice Training & Education	Resident Days	440,525	23			18,500		15
16	24	Travel and Seminar	Resident Days	440,525	23	10		18,500	1	16
17	25	Other Admin. Staff Transport.	Resident Days	440,525	23	33,098		18,500	1,390	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	440,525	23			18,500		18
19	27	Mgmt. Allocation of Benefits	Resident Days	440,525	23	176,624		18,500	7,417	19
20	30	Depreciation	Resident Days	440,525	23	24,996		18,500	1,050	20
21	32	Interest	Resident Days	440,525	23	933,842		18,500	39,217	21
22	33	Real Estate Taxes	Resident Days	440,525	23			18,500		22
23	34	Rent-Facility and Grounds	Resident Days	440,525	23			18,500		23
24	35	Rent-Equipment & Vehicles	Resident Days	440,525	23			18,500		24
25	TOTALS					\$ 1,709,403	\$ 324,344		\$ 71,789	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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.		\$	19,100	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	\$	19,531	2
3. Under or (over) accrual (line 2 minus line 1).		\$	431	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	20,500	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		\$	605	6
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.		\$	21,536	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2002		8	
	2003		9	
	2004		10	
	2005	19,096	11	
	2006	19,531	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 Newman Rehabilitation & Health Care Center COUNTY Douglas

FACILITY IDPH LICENSE NUMBER 0047506

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 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>07-06-31-400-012</u>	<u>Long-Term Care Facility</u>	\$ <u>19,531.00</u>	\$ <u>19,531.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>19,531.00</u>	\$ <u>19,531.00</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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 20,206 B. General Construction Type: Exterior Brick Frame Protected Number of Stories 1

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

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

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

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>20,206</u>	<u>2005</u>	\$	<u>1</u>
2					<u>2</u>
3	TOTALS	20,206		\$	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4				\$	\$		\$	\$	\$
5									
6									
7	Home Office Allocation			10,314			252	252	
8									
Improvement Type**									
9									
10	Sidewalks		2006	5,535		8	692	692	1,038
11	2 Rooftop A/C		2006	11,726		5	2,345	2,345	3,518
12	Roof		2007	43,864		20	1,097	1,097	1,097
13	Water Heater		2007	25,462		10	1,273	1,273	1,273
14									
15									
16									
17									
18									
19									
20									
21									
22	Building Improvement Booked				6,846			(6,846)	
23									
24									
25									
26									
27									
28									
29									
30							41	41	
31	2007-Home Office Allocation-Building Improvements			690					
32									
33									
34									
35									
36									

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

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

See Page 12A, Line 70 for total

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)	\$ 97,591	\$ 6,846		\$ 5,700	\$ (1,146)	\$ 6,926	70

**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	\$ 9,049	\$ 2,743	\$ 2,743	\$	3-5	\$ 6,447	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Home Office Allocation			3,098	3,098			74
75	TOTALS	\$ 9,049	\$ 2,743	\$ 5,841	\$ 3,098		\$ 6,447	75

D. Vehicle Depreciation (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 106,640	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 9,589	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 11,541	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,952	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 13,373	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: Springwood Associates Limited Partnership

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

If NO, see instructions.

	1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		<u>12/1/1992</u>	\$ <u>190,226</u>	<u>16</u>	<u>N/A</u>	3
4	Additions						4
5							5
6	<u>Home Office Allocation</u>			<u>37</u>			6
7	TOTAL			\$ <u>190,263</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 37 months

188,100
580,000

9. Option to Buy: YES NO Terms: N/A *

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

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ 2,722 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 12/1/1992
Ending 12/1/2008

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	<u>174,548 /2008</u>	\$ <u>190,749</u>
13.	<u>/2009</u>	\$
14.	<u>/2010</u>	\$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Newman Rehabilitation & Health Care Center
0047506

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

Medical Equipment-Refund \$	(2,604)
Dishwasher	561
Maintenance Equipment	28
Copier	4,250
Home Office Allocation	487
	<u>2,722</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		Contract	Total
		1 Drop-outs	2 Completed		
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	10A(3)	hrs	\$	8,869	\$ 133,034	\$	8,869	\$ 133,034	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		141	2,121		141	2,121	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		8,437	126,559		8,437	126,559	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				22,485		22,485	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			\$	17,447	\$ 261,714	\$ 22,485	17,447	\$ 284,199	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.

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 239,305	1
2	Restatements (describe):		2
3	<u>Rounding</u>	(1)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 239,304	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	200,972	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)	\$ 200,972	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)	\$ 440,276	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached. Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 1,931,902	1
2	Discounts and Allowances for all Levels	67,395	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,999,297	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	392,720	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 392,720	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	800	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	53,875	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	3,027	20
21	Other Medical Services	2,916	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 60,618	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	635	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 635	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	<u>Miscellaneous Revenue</u>	108	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 108	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,453,378	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	435,461	31
32	Health Care	983,619	32
33	General Administration	309,399	33
	B. Capital Expense		
34	Ownership	447,109	34
	C. Ancillary Expense		
35	Special Cost Centers	43,968	35
36	Provider Participation Fee	32,850	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,252,406	40
41	Income before Income Taxes (line 30 minus line 40)**	200,972	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 200,972	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 Newman Rehabilitation & Health Care Center

0047506

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	\$ 57,799	\$ 27.79	1
2	Assistant Director of Nursing	722	722	15,033	20.82	2
3	Registered Nurses	1,751	1,815	35,138	19.36	3
4	Licensed Practical Nurses	8,602	8,810	147,244	16.71	4
5	CNAs & Orderlies	32,512	33,760	304,796	9.03	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,830	2,034	25,141	12.36	9
10	Activity Assistants	874	874	6,605	7.56	10
11	Social Service Workers	2,080	2,080	22,701	10.91	11
12	Dietician					12
13	Food Service Supervisor	1,911	2,049	26,906	13.13	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,267	9,540	71,128	7.46	15
16	Dishwashers					16
17	Maintenance Workers	2,065	2,089	32,639	15.62	17
18	Housekeepers	8,565	8,043	73,140	9.09	18
19	Laundry	1,828	1,886	13,953	7.40	19
20	Administrator	1,993	1,993	33,590	16.85	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,812	1,944	24,423	12.56	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	1,449	1,550	16,961	10.94	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Care Plan Coord.</u>	1,863	1,967	36,480	18.55	33
34	TOTAL (lines 1 - 33)	81,204	83,236	\$ 943,677 *	\$ 11.34	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	7 hours	\$ 368	1(3)	35
36	Medical Director	Monthly	11,000	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	388	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)		\$ 11,756		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

Newman Rehabilitation & Health Care Center

0047506

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)		8,105

Home Office Allocation

Pearl & Associates	Legal	20
Addy Bush & Assoc	Legal	10
Registered Agent Solutions	Legal	2
Heyl, Royster, Voelker & Allen	Legal	45
Duane Morris	Legal	70
Ginoli & Co.	Accountants	2,303
RSM McGladrey	Accountants	124
McGladrey & Pullen	Accountants	189
Emdeon Business Services	Computer Services	49
Advanced Answers on Demand	Computer Services	1,327
Access 2 Go	Computer Services	100
Ivans	Computer Services	445
Kemper Technology	Computer Services	208
Adminastar Federal	Computer Services	26
Logmein	Computer Services	16
E-Health Data Solutions	Computer Services	130
Miscellaneous Vendors	Computer Services	16
Julie Breedlove	Computer Services	15
Amerisearch	Employment Fees	602

Total (agree to Schedule V, line 19, column 8)	<u>13,802</u>
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Facility Name & ID Number Newman Rehabilitation & Health Care Center

0047506

Report Period Beginning: 01/01/2007

Ending: 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-\$2,043
- (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. \$ 0 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. \$ 32,850
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (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. \$ 800
- (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? No If no, please explain. Audit still 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