



Facility Name & ID Number Kewanee Care Home

# 0026518 Report Period Beginning: 1/1/2008 Ending: 12/31/2008

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>9,882</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>57</u>	Intermediate (ICF)	<u>57</u>	<u>20,862</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>30,744</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>3,514</u>	<u>3,514</u>	8
9	SNF/PED					9
10	ICF	<u>14,005</u>	<u>6,566</u>		<u>20,571</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>14,005</u>	<u>6,566</u>	<u>3,514</u>	<u>24,085</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.34%

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 \_\_\_\_\_

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 3,467

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: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number Kewanee Care Home # 0026518 Report Period Beginning: 1/1/2008 Ending: 12/31/2008

**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
	<b>A. General Services</b>										
1	Dietary	126,073	14,330		140,403		140,403	4,273	144,676		1
2	Food Purchase		123,671		123,671		123,671	(1,056)	122,615		2
3	Housekeeping	104,976	15,041		120,017		120,017	32	120,049		3
4	Laundry	22,316	12,367		34,683		34,683	2	34,685		4
5	Heat and Other Utilities			97,900	97,900		97,900	443	98,343		5
6	Maintenance	24,150	21,996	38,359	84,505		84,505	1,058	85,563		6
7	Other (specify):* Home Off. Ben. All.							1,050	1,050		7
8	<b>TOTAL General Services</b>	277,515	187,405	136,259	601,179		601,179	5,802	606,981		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	830,017	65,787	9,769	905,573		905,573	6,126	911,699		10
10a	Therapy	105,545	222	35,946	141,713		141,713		141,713		10a
11	Activities	45,827	188	1,811	47,826		47,826	(172)	47,654		11
12	Social Services	19,538			19,538		19,538		19,538		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.							1,295	1,295		15
16	<b>TOTAL Health Care and Programs</b>	1,000,927	66,197	59,526	1,126,650		1,126,650	7,249	1,133,899		16
	<b>C. General Administration</b>										
17	Administrative	53,769			53,769		53,769	33,261	87,030		17
18	Directors Fees										18
19	Professional Services			6,269	6,269		6,269	3,754	10,023		19
20	Dues, Fees, Subscriptions & Promotions			8,010	8,010		8,010	241	8,251		20
21	Clerical & General Office Expenses	59,339	5,911	9,819	75,069		75,069	41,265	116,334		21
22	Employee Benefits & Payroll Taxes			198,559	198,559		198,559		198,559		22
23	Inservice Training & Education							254	254		23
24	Travel and Seminar			1,097	1,097		1,097	254	1,351		24
25	Other Admin. Staff Transportation			9,103	9,103		9,103	3,286	12,389		25
26	Insurance-Prop.Liab.Malpractice			18,529	18,529		18,529	200	18,729		26
27	Other (specify):* Home Off. Ben. All.							11,883	11,883		27
28	<b>TOTAL General Administration</b>	113,108	5,911	251,386	370,405		370,405	94,398	464,803		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,391,550	259,513	447,171	2,098,234		2,098,234	107,449	2,205,683		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 &amp; ID Number

Kewanee Care Home

#0026518

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

## 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	
	<b>D. Ownership</b>											
30	Depreciation			65,541	65,541		65,541	27,829	93,370			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			368,247	368,247		368,247	(2,218)	366,029			32
33	Real Estate Taxes			32,813	32,813		32,813	(1,698)	31,115			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			29,413	29,413		29,413	520	29,933			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			496,014	496,014		496,014	24,433	520,447			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		96,174		96,174		96,174		96,174			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			46,116	46,116		46,116		46,116			42
43	Other (specify):* Non-allowable Cost	18,300	405	94,027	112,732		112,732	(112,732)				43
44	<b>TOTAL Special Cost Centers</b>	18,300	96,579	140,143	255,022		255,022	(112,732)	142,290			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,409,850	356,092	1,083,328	2,849,270		2,849,270	19,150	2,868,420			45

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



Kewanee Care Home

ID# 0026518

Report Period Beginning: 1/1/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (11,252)	43	1
2	X-Rays-Part A	(5,018)	43	2
3	Resident Flowers	(29)	43	3
4	R.E. Tax on Non-Care Asset	(2,308)	33	4
5	Offset of Miscellaneous Income	(1,765)	10&21	5
6	Disallowed mortgage int. on non-care house	(5,388)	32	6
7	Offset of Transportation Income	(172)	43	7
8	Offset of Management Fee Income	(1,553)	6	8
9	Offset Chamber of Commerce Dues	(917)	20	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	<b>Total</b>	(28,402)		49

**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%	\$ 4,273	\$ 4,273	1	
2	V	2 Food		Petersen Health Care, Inc.	100.00%	70	70	2	
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	32	32	3	
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	2	2	4	
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	443	443	5	
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	2,611	2,611	6	
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,050	1,050	7	
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	7,416	7,416	8	
9	V	11 Activities		Petersen Health Care, Inc.	100.00%	0		9	
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,295	1,295	10	
11	V	17 Administrative		Petersen Health Care, Inc.	100.00%	33,261	33,261	11	
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	3,754	3,754	12	
13	V							13	
14	Total		\$			\$ 54,207	\$ *	54,207	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%	\$ 1,158	\$	1,158	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	41,740		41,740	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	254		254	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	254		254	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	3,286		3,286	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	200		200	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	11,883		11,883	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	4,547		4,547	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	3,199		3,199	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	610		610	24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0			25
26	V	35 Rent-Equipment and Vehicles		Petersen Health Care, Inc.	100.00%	520		520	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	<b>Total</b>		\$			\$ 67,651	\$ *	67,651	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: 1/1/2008 Ending: 12/31/2008

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	1,795,413	1.00	1.66	Salary	33,261	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	\$		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: 1/1/2008Ending: 2/31/2008

## 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	1,413,604	69	\$ 251,260	\$ 250,687	24,085	\$ 4,273	1
2	2	Food	Resident Days	1,413,604	69	4,125	0	24,085	70	2
3	3	Housekeeping	Resident Days	1,413,604	69	1,859	0	24,085	32	3
4	4	Laundry	Resident Days	1,413,604	69	110	0	24,085	2	4
5	5	Utilities	Resident Days	1,413,604	69	26,036	0	24,085	443	5
6	6	Maintenance	Resident Days	1,413,604	69	153,551	100,245	24,085	2,611	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	61,774	0	24,085	1,050	7
8	10	Nursing and Medical Records	Resident Days	1,413,604	69	436,084	432,530	24,085	7,416	8
9	10A	Therapy	Resident Days	1,413,604	69	0	0	24,085	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	76,136	0	24,085	1,295	10
11	17	Administrative	Resident Days	1,413,604	69	1,955,999	1,956,000	24,085	33,261	11
12	19	Professional Services	Resident Days	1,413,604	69	220,762	0	24,085	3,754	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,413,604	69	68,094	0	24,085	1,158	13
14	21	Clerical and General Office	Resident Days	1,413,604	69	2,454,596	2,013,896	24,085	41,740	14
15	23	Inservice Training & Education	Resident Days	1,413,604	69	14,912	0	24,085	254	15
16	24	Travel and Seminar	Resident Days	1,413,604	69	14,938	0	24,085	254	16
17	25	Other Admin. Staff Transport.	Resident Days	1,413,604	69	193,264	0	24,085	3,286	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,413,604	69	11,767	0	24,085	200	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	698,810	0	24,085	11,883	19
20	30	Depreciation	Resident Days	1,413,604	69	267,426	0	24,085	4,547	20
21	32	Interest	Resident Days	1,413,604	69	188,107	0	24,085	3,199	21
22	33	Real Estate Taxes	Resident Days	1,413,604	69	35,872	0	24,085	610	22
23	34	Rent-Facility and Grounds	Resident Days	1,413,604	69	0	0	24,085	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,413,604	69	30,580	0	24,085	520	24
25	TOTALS					\$ 7,166,062	\$ 4,753,358		\$ 121,858	25

Facility Name & ID Number

Kewanee Care Home

# 0026518

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	Bank of America		X	Mortgage	Varies	1/17/07	\$ 5,775,000	\$ 5,631,823	12/31/13	Varies	\$ 362,859	1						
2												2						
3							Interest Income Offset				(29)	3						
4							Home Office Allocation-PHC				3,199	4						
5												5						
<b>Working Capital</b>																		
6												6						
7												7						
8												8						
9	<b>TOTAL Facility Related</b>						\$ 5,775,000	\$ 5,631,823			\$ 366,029	9						
<b>B. Non-Facility Related*</b>																		
10	Associated Bank		X	Mortgage on House	\$879.00	11/16/05	70,500	55,275	10/16/15	0.0850	5,388	10						
11												11						
12									Disallowed interest		(5,388)	12						
13												13						
14	<b>TOTAL Non-Facility Related</b>				\$879.00		\$ 70,500	\$ 55,275			\$	14						
15	<b>TOTALS (line 9+line14)</b>						\$ 5,845,500	\$ 5,687,098			\$ 366,029	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.)



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

**2007 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 2007 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 2007.

(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>113.96</u>	\$ <u>113.96</u>
2. <u>25-04-151-009</u>	<u>144 Junior Ave.</u>	\$ <u>86.26</u>	\$ <u>86.26</u>
3. <u>24-04-152-001</u>	<u>821 Dewey Ave.</u>	\$ <u>27,305.38</u>	\$ <u>27,305.38</u>
4. <u>25-04-451-014</u>	<u>529 Whitney Avenue</u>	\$ <u>2,307.58</u>	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>29,813.18</u>	\$ <u>27,505.60</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 DISALLO' 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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

**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:

1/1/2008 Ending:

12/31/2008

**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	<b>TOTALS</b>	<b>53,250</b>		<b>\$ 50,621</b>	<b>3</b>

Facility Name &amp; ID Number Kewanee Care Home

# 0026518

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

**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	199,895	5
6	8	2002	2002	672,751		40	16,819	16,819	75,684	6
7										7
8										8
	<b>Improvement Type**</b>									
9	Various		1984	14,365		30	479	479	11,529	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	20,802	17
18	Various		1995	31,243		20	1,562	1,562	21,124	18
19	Tile Flooring		1996	1,083		20	54	54	693	19
20	Curtains Custom		1996	1,275		20	64	64	747	20
21	Emergency Light		1996	304		20	15	15	190	21
22	Fire Alarm		1996	2,099		20	105	105	1,330	22
23	Tile Flooring		1996	1,287		20	64	64	805	23
24	Boiler		1996	2,996		20	150	150	1,838	24
25	Water Heater Repair		1996	1,010		20	51	51	659	25
26	Ceiling Repairs		1996	2,117		20	106	106	1,369	26
27	Piping Repairs		1996	855		20	43	43	555	27
28	Fire Alarm		1996	1,331		20	67	67	815	28
29	Fire System		1996	1,564		20	78	78	969	29
30	Landscaping		1996	9,815		20	491	491	6,178	30
31	Landscaping		1996	1,986		20	99	99	1,221	31
32	Chrome Door Knob		1996	72		20	4	4	51	32
33	Emergency Light		1996	182		20	9	9	117	33
34	Painting		1996	672		20	34	34	436	34
35	Floor Tile		1997	8,472		20	424	424	5,017	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 &amp; ID Number Kewanee Care Home

# 0026518

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

**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	\$ 5,811	37
38	Windows	1997	5,136		20	257	257	2,956	38
39	Ceiling Repairs	1997	8,291		20	415	415	4,703	39
40	Landscaping	1997	8,085		20	404	404	4,545	40
41	Landscaping	1997	1,298		20	65	65	731	41
42	Whirlpool	1997	9,343		20	467	467	5,176	42
43	Boiler	1997	3,000		20	150	150	1,675	43
44	Wing Additions	1997	3,700		20	185	185	2,050	44
45	Attic Piping	1997	3,318		20	166	166	1,895	45
46	Compressor	1997	809		20	40	40	443	46
47	Fire Alarm	1997	2,338		20	117	117	1,366	47
48	Code Alert Receiver	1997	1,863		20	93	93	1,085	48
49	New sign	1998	7,304		20	365	365	6,570	49
50	Landscaping	1998	21,500		20	1,075	1,075	11,467	50
51	Duct Work-New Wing	1999	1,494		20	75	75	712	51
52	Tiling	1999	914		20	46	46	437	52
53	Water Heater	1999	2,835		20	142	142	1,349	53
54	Water Heater	1999	3,766		20	188	188	1,786	54
55	Cubicle Partitions	1999	701		20	35	35	332	55
56	Beauty Salon	2000	943		20	47	47	400	56
57	Tile Flooring	2000	10,294		20	515	515	4,377	57
58	Lot/House Razed	2000	21,237		20	1,062	1,062	9,027	58
59	Concrete	2001	900		15	60	60	480	59
60	Landscaping	2001	1,045		15	70	70	561	60
61	Lighting	2001	3,438		39	88	88	704	61
62	Blinds/Curtains	2001	9,500		7			9,500	62
63	Landscaping	2002	24,614		15	1,641	1,641	10,666	63
64	Landscaping	2002	4,075		15	272	272	1,768	64
65	Architectural	2002	21,778		20	1,089	1,089	7,078	65
66	Carpeting	2002	2,551		20	128	128	832	66
67	Fire System	2002	4,677		20	234	234	1,521	67
68	Landscaping	2003	4,899		15	327	327	1,798	68
69	Simplex Time Clock	2004	3,198		10	320	320	1,440	69
70	TOTAL (lines 4 thru 69)		\$ 2,186,671	\$		\$ 51,684	\$ 51,684	\$ 903,582	70

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

Facility Name &amp; ID Number Kewanee Care Home

# 0026518

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

## 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	
1	Totals from Page 12A, Carried Forward		\$ 2,186,671	\$		\$ 51,684	\$ 51,684	\$ 903,582	1
2	Air Conditioner	2004	2,700		10	270	270	1,215	2
3	Side walks	2005	2,065		15	138	138	552	3
4	Floor covering	2005	13,891		7	1,984	1,984	7,936	4
5	Flooring	2006	28,527		25	1,141	1,141	2,853	5
6	Driveway	2007	7,101		15	473	473	710	6
7	Boiler	2007	2,895		10	290	290	435	7
8	Sprinkler System Repair	2008	2,583		5	258	258	258	8
9	Painting of Dining Room	2008	2,825		39	36	36	36	9
10	Sprinkler System Repair	2008	2,689		5	269	269	269	10
11									11
12									12
13									13
14	Building Booked			19,325			(19,325)		14
15	Building Improvement Booked			32,529			(32,529)		15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	2008-Home Office Allocation-Land Improvements		835			54	54		25
26	2008-Home Office Allocation-Building Improvements		12,481			299	299		26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,265,263	\$ 51,854		\$ 56,896	\$ 5,042	\$ 917,846	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	\$ 316,319	\$ 9,887	\$ 31,632	\$ 21,745	7-10 yrs.	\$ 234,325	71
72	Current Year Purchases	5,896	250	295	45	10	295	72
73	Fully Depreciated Assets	107,989					107,989	73
74	Home Office Allocation			4,547	4,547			74
75	TOTALS	\$ 430,204	\$ 10,137	\$ 36,474	\$ 26,337		\$ 342,609	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		(1,775)	5	35,088	77
78										78
79										79
80	TOTALS			\$ 67,457	\$ 3,550	\$	\$ (3,550)		\$ 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)	\$ 2,813,545	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 65,541	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 93,370	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 27,829	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,327,912	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					87
88	N/A				88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			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: \$ 7,963 Description: See Attached 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	Facility	Ford E250	\$ 578.00	\$ 21,970	17
18					18
19					19
20					20
21	TOTAL		\$ 578.00	\$ 21,970	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. \_\_\_\_\_ /2009 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2010 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2011 \$ \_\_\_\_\_

\* 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 1/1/2008**

**Period End 12/31/2008**

**Schedule 14A**

**XII. Rental Costs**

**B. Equipment**

**16. Description of rental amount for movable equipment**

Medical Equipment	\$	3,998
Dishwasher		708
Maintenance Equipment		400
Copier		2,337
Home Office Allocation		520
		<u>7,963</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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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)	637	hrs	\$ 23,298	133	\$ 1,992	\$	770	\$ 25,290	1
2	Licensed Speech and Language Development Therapist	10A(3)		hrs		846	12,684		846	12,684	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	3499	hrs	82,247	1,418	21,270	222	4,917	103,739	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				96,174		96,174	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): _____										12
13	Other (specify): _____										13
14	<b>TOTAL</b>				\$ 105,545	2,397	\$ 35,946	\$ 96,396	6,533	\$ 237,887	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name &amp; ID Number      Kewanee Care Home

#      0026518

Report Period Beginning:      1/1/2008

Ending:      12/31/2008

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of      12/31/2008

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 8,717,473	\$ 8,717,473	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>N/A</u> )	905,261	905,261	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	20,869	20,869	6
7	Other Prepaid Expenses	10,603	10,603	7
8	Accounts Receivable (owners or related parties)	960,271	960,271	8
9	Other(specify): _____			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 10,614,477	\$ 10,614,477	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	158,696	50,621	13
14	Buildings, at Historical Cost	1,162,445	1,820,056	14
15	Leasehold Improvements, at Historical Cost	988,262	445,207	15
16	Equipment, at Historical Cost	531,937	497,661	16
17	Accumulated Depreciation (book methods)	(1,372,690)	(1,327,912)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify): _____			22
23	Other(specify): <u>Non-Care House</u>	70,500	70,500	23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 1,539,150	\$ 1,556,133	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 12,153,627	\$ 12,170,610	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 387,548	\$ 387,548	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	86,950	86,950	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,412	3,412	31
32	Accrued Real Estate Taxes(Sch.IX-B)	31,000	31,000	32
33	Accrued Interest Payable	33,174	33,174	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Payroll Withholdings</u>	37,848	37,848	36
37	_____			37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 579,932	\$ 579,932	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable	5,687,098	5,687,098	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>Deferred Income</u>	6,602	6,602	43
44	_____			44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 5,693,700	\$ 5,693,700	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 6,273,632	\$ 6,273,632	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 5,879,995	\$ 5,896,978	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 12,153,627	\$ 12,170,610	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>5,293,305</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>5,293,305</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>586,690</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>586,690</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>5,879,995</b>	<b>24</b> *

\* 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	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 2,739,823	1
2	Discounts and Allowances for all Levels	240,532	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,980,355	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	268,434	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 268,434	8
	<b>C. Other Operating Revenue</b>		
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	1,126	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	169,949	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	7,874	20
21	Other Medical Services	4,703	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 183,652	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	29	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 29	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Miscellaneous Revenue	1,937	28
28a	Transportation Revenue	1,553	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 3,490	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,435,960	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	601,179	31
32	Health Care	1,126,650	32
33	General Administration	370,405	33
	<b>B. Capital Expense</b>		
34	Ownership	496,014	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	208,906	35
36	Provider Participation Fee	46,116	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,849,270	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	586,690	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 586,690	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 part of 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 Kewanee Care Home

# 0026518

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

**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	\$ 54,750	\$ 26.32	1
2	Assistant Director of Nursing	900	940	18,167	19.33	2
3	Registered Nurses	4,155	4,214	90,990	21.59	3
4	Licensed Practical Nurses	14,778	15,257	249,505	16.35	4
5	CNAs & Orderlies	42,041	43,625	416,605	9.55	5
6	CNA Trainees					6
7	Licensed Therapist	2,654	2,654	79,548	29.97	7
8	Rehab/Therapy Aides	1,467	1,482	25,997	17.54	8
9	Activity Director	1,623	1,639	15,531	9.48	9
10	Activity Assistants	1,516	1,530	11,737	7.67	10
11	Social Service Workers	1,860	1,860	19,538	10.50	11
12	Dietician					12
13	Food Service Supervisor	2,077	2,077	22,252	10.71	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,921	13,256	103,821	7.83	15
16	Dishwashers					16
17	Maintenance Workers	1,870	1,893	24,150	12.76	17
18	Housekeepers	12,224	12,490	104,976	8.40	18
19	Laundry	3,075	3,210	22,316	6.95	19
20	Administrator	2,080	2,080	53,769	25.85	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	4,312	4,428	59,339	13.40	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: <u>Transportation</u>	1,948	2,044	18,559	9.08	32
33	Other(specify) <u>Marketing</u>	1,300	1,300	18,300	14.08	33
34	TOTAL (lines 1 - 33)	114,881	118,059	\$ 1,409,850 *	\$ 11.94	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 1,440	10(3)	37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 1,630	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)	\$ 15,070		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

Kewanee Care Home  
 0026518  
 Period Beginning 1/1/2008  
 Period End 12/31/2008

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Director of Nursing	2,080	2,080	54,750	26.32
Assistant Director of Nsg.	900	940	18,167	19.33
Registered Nurses	4,155	4,214	90,990	21.59
Licensed Practical Nurses	14,778	15,257	249,505	16.35
Nurse Aides & Orderlies	42,041	43,625	416,605	9.55
Nurse Aide Trainees				
Licensed Therapist				
Activity Director	1,623	1,639	15,531	9.48
Activity Assistants	1,516	1,530	11,737	7.67
Social Service Workers	1,860	1,860	19,538	10.50
Dietician				
Food Service Supervisor	2,077	2,077	22,252	10.71
Head Cook				
Cook Helpers/Assistants	12,921	13,256	103,821	7.83
Dishwashers				
Maintenance Workers	1,870	1,893	24,150	12.76
Housekeepers	12,224	12,490	104,976	8.40
Laundry	3,075	3,210	22,316	6.95
Administrator	2,080	2,080	53,769	25.85
Assistant Administrator				
Other Administrative				
Office	4,312	4,428	59,339	13.40
Clerical				
Vocational Instruction				
Academic Instruction				
Housekeeping Supervisor				
Licensed Occ. Therapist	571	571	22,788	39.91
Physical Therapy Asst	2,080	2,080	56,622	27.22
Licensed Physical Therapist	3	3	138	50.00
Medical Records				
Care Plan Coordinator				
Physical therapy aide	1,401	1,416	25,487	17.99
COTA	66	66	510	7.79
Therapist				
Transportation	1,948	2,044	18,559	9.08
Marketing	1,300	1,300	18,300	14.08
<b>TOTAL (lines 1 - 35)</b>	<b>114,881</b>	<b>118,058</b>	<b>1,409,850</b>	

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

# **0026518**

Report Period Beginning: **1/1/2008**

Ending: **12/31/2008**

**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	
Nathaniel Smith	Administrator	0	\$ 53,769	Workers' Compensation Insurance	\$ 54,367	IDPH License Fee	\$	
				Unemployment Compensation Insurance	24,324	Advertising: Employee Recruitment	1,593	
				FICA Taxes	108,037	Health Care Worker Background Check (Indicate # of checks performed )		
				Employee Health Insurance	5,903	Patient Background Checks	187	
				Employee Meals		Miscellaneous Dues & Subscriptions	917	
				Illinois Municipal Retirement Fund (IMRF)*		Home Office Allocation	1,158	
				Employee Relations	4,092	Miscellaneous Licenses & Permits	390	
				Employee Retirement	1,761	IHCA Dues	3,240	
				Employee Life Insurance	75			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 53,769	TOTAL (agree to Schedule V, line 22, col.8)		\$ 8,251		
B. Administrative - Other							Less: Public Relations Expense	
Description			Amount				(917)	
N/A			\$				Non-allowable advertising ( )	
							Yellow page advertising ( )	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$				TOTAL (agree to Sch. V, line 20, col. 8)	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Insight Communications	Computer Services		\$ 140			\$	Out-of-State Travel	\$
Comcast Communications	Computer Services		1,539					
E-Health Data Solutions	Computer Services		2,700					
LTC Solutions	Computer Services		1,600	N/A			In-State Travel	
Farnsworth Group	Architectural Services		290					
							Seminar Expense	1,097
							Home Office Allocation	254
							Entertainment Expense ( )	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 6,269	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	
							\$ 1,351	

\* Attach copy of IMRF notifications

\*\*See instructions.

**Kewanee Care Home**

0026518

Period Beginning 1/1/2008

Period End 12/31/2008

**Schedule 21A****XIX. SUPPORT SCHEDULE****C. Professional Services**

<b>Vendor/Payee</b>	<b>Type</b>	<b>Amount</b>
Total (agree to Schedule V, line 19, column 3)		6,269

**Home Office Allocation**

Heyl, Royster, Voelker & Allen	Legal	136
GoffWilson, P.A.	Legal	456
Ginoli & Company	Accountants	1,107
RSM McGladrey	Accountants	10
Miscellaneous Vendors	Computer Services	53
Emdeon Business Services	Computer Services	73
Advanced Answers on Demand	Computer Services	863
Access 2 Go	Computer Services	255
Ivans	Computer Services	132
Kemper Technology	Computer Services	467
VisionShare	Computer Services	50
Logmein	Computer Services	36
Comm Net Communiations	Computer Services	13
Charter Communications	Computer Services	11
Advanced System Designs	Computer Services	17
Consolidated Communications	Computer Services	10
Miscellaneous Vendors	Miscellaneous	65

Total (agree to Schedule V, line 19, column 8)	<u>10,023</u>
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**Kewanee Care Home**

**0026518**

**Period Beginning**

**1/1/2008**

**Period End**

**12/31/2008**

**Schedule 21B**

**XIX. SUPPORT SCHEDULES**

**A. Administrative Salaries**

<u>Name</u>	<u>Function</u>	<u>Ownership %</u>	<u>Amount</u>
Nathaniel Smith	Administrator	0	53,769
	Total		<u>53,769</u>



Facility Name & ID Number Kewanee Care Home# 0026518Report Period Beginning: 1/1/2008Ending: 12/31/2008**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-\$3,240
- (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? No
- (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. \$ 8,009 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? N/A  
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. \$ 46,116  
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. \$ 1,126
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ No  
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? N/A  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ No
- (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 currently in progress
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$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