

		FOR BHF USE					

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH Facility ID Number: <u>0047563</u></p> <p>Facility Name: <u>Shelbyville Rehabilitation & Health Care Center</u></p> <p>Address: <u>2116 South 3rd & Dacey Drive</u> <u>Shelbyville</u> <u>62565</u> Number City Zip Code</p> <p>County: <u>Shelby</u></p> <p>Telephone Number: <u>217-774-2138</u> Fax # <u>217-774-2317</u></p> <p>HFS ID Number: <u>20-3224201018</u></p> <p>Date of Initial License for Current Owners: <u>10/1/05</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Christine Hanover</u> Telephone Number: <u>(312) 634-4581</u> Please send copies of desk review and audit adjustments to address on this page.</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/06</u> to <u>12/31/06</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 20%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td align="right">(Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) _____</td> </tr> <tr> <td></td> <td>(Title) _____</td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u></td> </tr> <tr> <td align="right">(Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____</td> </tr> <tr> <td>(Firm Name & Address) <u>McGladrey & Pullen, LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(312) 384-6000</u> Fax # <u>(312) 634-5518</u></td> </tr> <tr> <td></td> <td>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Date) _____		(Type or Print Name) _____		(Title) _____	Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u>	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) <u>McGladrey & Pullen, LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u>		(Telephone) <u>(312) 384-6000</u> Fax # <u>(312) 634-5518</u>		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shelbyville Rehabilitation & Health Care Center

0047563 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	12	Skilled (SNF)	12	4,380	1
2		Skilled Pediatric (SNF/PED)			2
3	68	Intermediate (ICF)	68	24,820	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	80	TOTALS	80	29,200	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			1,381	1,381	8
9	SNF/PED					9
10	ICF	10,121	1,742		11,863	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,121	1,742	1,381	13,244	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 45.36%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
N/A

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 10/1/05

J. Was the facility purchased or leased after January 1, 1978?
YES Date 10/1/05 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 12 and days of care provided 1,381

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: 12/31/2006 Fiscal Year: 12/31/2006

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

Facility Name & ID Number Shelbyville Rehabilitation & Health Care Ce # 0047563 Report Period Beginning: 01/01/06 Ending: 12/31/06

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	99,988	8,015		108,003		108,003	1,316	109,319		1
2	Food Purchase		66,046		66,046		66,046	(7,536)	58,510		2
3	Housekeeping	37,202	6,687		43,889		43,889	43	43,932		3
4	Laundry	13,448	5,766		19,214		19,214		19,214		4
5	Heat and Other Utilities			59,822	59,822		59,822	175	59,997		5
6	Maintenance	25,223	26,072	182	51,477		51,477	3,262	54,739		6
7	Other (specify):* Home Office Benefits							819	819		7
8	TOTAL General Services	175,861	112,586	60,004	348,451		348,451	(1,921)	346,530		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	469,988	59,564	13,509	543,061		543,061	4,065	547,126		10
10a	Therapy			79,723	79,723		79,723	313	80,036		10a
11	Activities	19,943	2,008	2,273	24,224		24,224		24,224		11
12	Social Services	25,563	22		25,585		25,585		25,585		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Office Benefits							1,279	1,279		15
16	TOTAL Health Care and Programs	515,494	61,594	101,505	678,593		678,593	5,657	684,250		16
	C. General Administration										
17	Administrative	48,094		32,000	80,094		80,094	(21,932)	58,162		17
18	Directors Fees										18
19	Professional Services			4,202	4,202		4,202	5,474	9,676		19
20	Dues, Fees, Subscriptions & Promotions			8,679	8,679		8,679	648	9,327		20
21	Clerical & General Office Expenses	15,061	4,335	10,162	29,558		29,558	18,769	48,327		21
22	Employee Benefits & Payroll Taxes			119,879	119,879		119,879	4,119	123,998		22
23	Inservice Training & Education			201	201		201	121	322		23
24	Travel and Seminar							349	349		24
25	Other Admin. Staff Transportation			1,469	1,469		1,469	1,429	2,898		25
26	Insurance-Prop.Liab.Malpractice			14,227	14,227		14,227	747	14,974		26
27	Other (specify):* Home Office Benefits							3,643	3,643		27
28	TOTAL General Administration	63,155	4,335	190,819	258,309		258,309	13,367	271,676		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	754,510	178,515	352,328	1,285,353		1,285,353	17,103	1,302,456		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			62,868	62,868		62,868	3,625	66,493			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			103,960	103,960		103,960	11,210	115,170			32
33	Real Estate Taxes			31,500	31,500		31,500	1,309	32,809			33
34	Rent-Facility & Grounds							596	596			34
35	Rent-Equipment & Vehicles			11,704	11,704		11,704	390	12,094			35
36	Other (specify):*											36
37	TOTAL Ownership			210,032	210,032		210,032	17,130	227,162			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			2,760	2,760		2,760		2,760			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			43,800	43,800		43,800		43,800			42
43	Other (specify):* Nonallowable Cost			62,710	62,710		62,710	(62,710)				43
44	TOTAL Special Cost Centers			109,270	109,270		109,270	(62,710)	46,560			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	754,510	178,515	671,630	1,604,655		1,604,655	(28,477)	1,576,178			45

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(2,389)	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	(786)	30		9
10	Interest and Other Investment Income	(2,392)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(273)	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				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(42,885)	43		24
25	Fund Raising, Advertising and Promotional	(2,704)	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>Wee Pg 5A</u>	(21,842)	Var		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (73,271)		\$	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)	44,794		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 44,794		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (28,477)		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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS
 Shelbyville Rehabilitation & Health Care Center

ID# 0047563

Report Period Beginning: 01/01/06

Ending: 12/31/06

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Nonallowable marketing events	\$ (2,973)	43	1
2	Labs - Part A	(10,285)	43	2
3	X-Rays - Part A	(901)	43	3
4	Marketing Supplies	(300)	43	4
5	Offset Meal Revenue	(3,466)	2	5
6	Nonallowable Travel	(3,623)	24	6
7	Nonallowable HO Architect Fees	(294)	19	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
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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	(21,842)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Shelbyville Rehabilitation & Health Care Center

0047563

Report Period Beginning:

01/01/06

Ending:

12/31/06

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	942	0	374	0	0	0	0	0	0	0	1,316	1
2	Food Purchase	(3,466)	46	0	3	0	0	0	0	0	0	0	(3,417)	2
3	Housekeeping	0	42	0	1	0	0	0	0	0	0	0	43	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	175	0	0	0	0	0	0	0	0	0	175	5
6	Maintenance	0	2,395	0	867	0	0	0	0	0	0	0	3,262	6
7	Other (specify):*	0	377	0	442	0	0	0	0	0	0	0	819	7
8	TOTAL General Services	(3,466)	3,977	0	1,687	0	2,198	8						
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	3,405	0	660	0	0	0	0	0	0	0	4,065	10
10a	Therapy	0	313	0	0	0	0	0	0	0	0	0	313	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	1,053	0	226	0	0	0	0	0	0	0	1,279	15
16	TOTAL Health Care and Programs	0	4,771	0	886	0	5,657	16						
	C. General Administration													
17	Administrative	0	(22,718)	0	786	0	0	0	0	0	0	0	(21,932)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(294)	4,066	0	1,702	0	0	0	0	0	0	0	5,474	19
20	Fees, Subscriptions & Promotions	0	398	0	250	0	0	0	0	0	0	0	648	20
21	Clerical & General Office Expenses	0	0	14,963	3,806	0	0	0	0	0	0	0	18,769	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	121	0	0	0	0	0	0	0	0	121	23
24	Travel and Seminar	(3,623)	0	3,623	349	0	0	0	0	0	0	0	349	24
25	Other Admin. Staff Transportation	0	0	964	465	0	0	0	0	0	0	0	1,429	25
26	Insurance-Prop.Liab.Malpractice	0	0	713	34	0	0	0	0	0	0	0	747	26
27	Other (specify):*	0	0	2,644	999	0	0	0	0	0	0	0	3,643	27
28	TOTAL General Administration	(3,917)	(18,254)	23,028	8,391	0	9,248	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(7,383)	(9,506)	23,028	10,964	0	17,103	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Shelbyville Rehabilitation & Health Care Center

0047563

Report Period Beginning:

01/01/06

Ending:

12/31/06

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS
													(to Sch V, col.7)
30	Depreciation	(786)	0	3,689	722	0	0	0	0	0	0	0	3,625 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(2,392)	0	2,049	11,553	0	0	0	0	0	0	0	11,210 32
33	Real Estate Taxes	0	0	433	876	0	0	0	0	0	0	0	1,309 33
34	Rent-Facility & Grounds	0	0	419	177	0	0	0	0	0	0	0	596 34
35	Rent-Equipment & Vehicles	0	0	220	170	0	0	0	0	0	0	0	390 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	TOTAL Ownership	(3,178)	0	6,810	13,498	0	17,130 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):*	(62,710)	0	0	0	0	0	0	0	0	0	0	(62,710) 43
44	TOTAL Special Cost Centers	(62,710)	0	0	0	0	0	0	0	0	0	0	(62,710) 44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(73,271)	(9,506)	29,838	24,462	0	(28,477) 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		See Attached Schedule 6A		See Attached Schedule 6A		

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

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

1	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%	\$ 942	\$ 942	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	46	46	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	42	42	3
4								4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	175	175	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	2,395	2,395	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	377	377	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	3,405	3,405	8
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	313	313	9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,053	1,053	10
11	V	17 Administrative	32,000	Petersen Health Care, Inc.	100.00%	9,282	(22,718)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	4,066	4,066	12
13	V	20 Due, Fees, Subs & Promos		Petersen Health Care, Inc.	100.00%	398	398	13
14	Total		\$ 32,000			\$ 22,494	\$ * (9,506)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	21	Clerical & General Office	\$	Petersen Health Care, Inc.	100.00%	\$ 14,963	\$ 14,963	15
16	V	23	Inservice Training & Education		Petersen Health Care, Inc.	100.00%	121	121	16
17	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	3,623	3,623	17
18	V	25	Other Admin. Staff Transport		Petersen Health Care, Inc.	100.00%	964	964	18
19	V	26	Insurance-Prop.Liab.Malpractice		Petersen Health Care, Inc.	100.00%	713	713	19
20	V	27	Mgmt Allocation of Benefits		Petersen Health Care, Inc.	100.00%	2,644	2,644	20
21	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	3,689	3,689	21
22	V	32	Interest		Petersen Health Care, Inc.	100.00%	2,049	2,049	22
23	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	433	433	23
24	V	34	Rent - Facility & Grounds		Petersen Health Care, Inc.	100.00%	419	419	24
25	V	35	Rent - Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	220	220	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$				\$ 29,838	\$ * 29,838	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 Care, Inc.	100.00%	\$ 374	\$	374	15
16	V	2 Food		Petersen Health Care, Inc.	100.00%	3		3	16
17	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	1		1	17
18									18
19									19
20	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	867		867	20
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	442		442	21
22	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	660		660	22
23									23
24	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	226		226	24
25	V	17 Administrative		Petersen Health Care, Inc.	100.00%	786		786	25
26	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	1,702		1,702	26
27	V	20 Due, Fees, Subs & Promos		Petersen Health Care, Inc.	100.00%	250		250	27
28	V	21 Clerical & General Office		Petersen Health Care, Inc.	100.00%	3,806		3,806	28
29									29
30	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	349		349	30
31	V	25 Other Admin. Staff Transport		Petersen Health Care, Inc.	100.00%	465		465	31
32	V	26 Insurance-Prop.Liab.Malpractice		Petersen Health Care, Inc.	100.00%	34		34	32
33	V	27 Mgmt Allocation of Benefits		Petersen Health Care, Inc.	100.00%	999		999	33
34	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	722		722	34
35	V	32 Interest		Petersen Health Care, Inc.	100.00%	11,553		11,553	35
36	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	876		876	36
37	V	34 Rent - Facility & Grounds		Petersen Health Care, Inc.	100.00%	177		177	37
38	V	35 Rent - Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	170		170	38
39	Total		\$			\$ 24,462	\$ *	24,462	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shelbyville Rehabilitation & Health Care Ce # 0047563 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	0.58	1.16	Salary	\$ 9,282	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	\$ 9,282		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shelbyville Rehabilitation & Health Care Center # 0047563 Report Period Beginning: 01/01/06 Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization Petersen Health Care, Inc.
 Street Address 830 West Trailcreek Drive
 City / State / Zip Code Peoria, IL 61614
 Phone Number (309) 691-8113
 Fax Number (309) 691-8622

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Patient Days	1,141,463	56	\$ 81,179	\$ 13,244	\$ 942	1
2	2	Food	Patient Days	1,141,463	56	3,989	13,244	46	2
3	3	Housekeeping	Patient Days	1,141,463	56	3,589	13,244	42	3
4									4
5	5	Utilities	Patient Days	1,141,463	56	15,054	13,244	175	5
6	6	Maintenance	Patient Days	1,141,463	56	206,416	110,513	2,395	6
7	7	Mgmt. Allocation of Benefits	Patient Days	1,141,463	56	32,526	13,244	377	7
8	10	Nursing and Medical Records	Patient Days	1,141,463	56	293,462	289,197	3,405	8
9	10A	Therapy	Patient Days	1,141,463	56	26,945	13,244	313	9
10	15	Mgmt. Allocation of Benefits	Patient Days	1,141,463	56	90,724	13,244	1,053	10
11	17	Administrative	Patient Days	1,141,463	56	800,000	800,000	9,282	11
12	19	Professional Services	Patient Days	1,141,463	56	350,361	4,303	4,066	12
13	20	Due, Fees, Subs & Promos	Patient Days	1,141,463	56	34,325	13,244	398	13
14	21	Clerical & General Office	Patient Days	1,141,463	56	1,289,623	954,322	14,963	14
15	23	Inservice Training & Education	Patient Days	1,141,463	56	10,426	13,244	121	15
16	24	Travel and Seminar	Patient Days	1,141,463	56	312,259	13,244	3,623	16
17	25	Other Admin. Staff Transport	Patient Days	1,141,463	56	83,062	13,244	964	17
18	26	Insurance-Prop.Liab.Malpractice	Patient Days	1,141,463	56	61,457	13,244	713	18
19	27	Mgmt Allocation of Benefits	Patient Days	1,141,463	56	227,912	13,244	2,644	19
20	30	Depreciation	Patient Days	1,141,463	56	317,964	13,244	3,689	20
21	32	Interest	Patient Days	1,141,463	56	176,614	13,244	2,049	21
22	33	Real Estate Taxes	Patient Days	1,141,463	56	37,282	13,244	433	22
23	34	Rent - Facility & Grounds	Patient Days	1,141,463	56	36,133	13,244	419	23
24	35	Rent - Equipment & Vehicles	Patient Days	1,141,463	56	18,933	13,244	220	24
25	TOTALS					\$ 4,510,235	\$ 2,239,302	\$ 52,332	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shelbyville Rehabilitation & Health Care Center # 0047563 Report Period Beginning: 01/01/06 Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization Petersen Health Care, Inc.
 Street Address 830 West Trailcreek Drive
 City / State / Zip Code Peoria, IL 61614
 Phone Number (309) 691-8113
 Fax Number (309) 691-8622

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	427,669	46	\$ 12,081	\$ 11,958	13,244	\$ 374	1
2	2	Food	427,669	46	93		13,244	3	2
3	3	Housekeeping	427,669	46	28		13,244	1	3
4									4
5									5
6	6	Maintenance	427,669	46	28,012	28,012	13,244	867	6
7	7	Mgmt. Allocation of Benefits	427,669	46	14,282		13,244	442	7
8	10	Nursing and Medical Records	427,669	46	21,299	20,434	13,244	660	8
9									9
10	15	Mgmt. Allocation of Benefits	427,669	46	7,301		13,244	226	10
11	17	Administrative	427,669	46	25,391	25,391	13,244	786	11
12	19	Professional Services	427,669	46	54,971		13,244	1,702	12
13	20	Due, Fees, Subs & Promos	427,669	46	8,088		13,244	250	13
14	21	Clerical & General Office	427,669	46	122,893	64,907	13,244	3,806	14
15									15
16	24	Travel and Seminar	427,669	46	11,280		13,244	349	16
17	25	Other Admin. Staff Transport	427,669	46	15,003		13,244	465	17
18	26	Insurance-Prop.Liab.Malpractice	427,669	46	1,087		13,244	34	18
19	27	Mgmt Allocation of Benefits	427,669	46	32,265		13,244	999	19
20	30	Depreciation	427,669	46	23,301		13,244	722	20
21	32	Interest	427,669	46	373,049		13,244	11,553	21
22	33	Real Estate Taxes	427,669	46	28,282		13,244	876	22
23	34	Rent - Facility & Grounds	427,669	46	5,700		13,244	177	23
24	35	Rent - Equipment & Vehicles	427,669	46	5,479		13,244	170	24
25	TOTALS				\$ 789,885	\$ 150,702		\$ 24,462	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shelbyville Rehabilitation & Health Care Cer # 0047563 Report Period Beginning: 01/01/06 Ending: 12/31/06

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		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
	A. Directly Facility Related																
	Long-Term																
1	LaSalle Bank		X	Mortgage	Varies	09/30/05	\$ 910,000	\$ 896,716	09/20/10	Varies	\$ 77,372	1					
2	Ziegler Healthcare		X	Mortgage	Varies	09/30/05	170,000	169,689	09/20/10	0.1000	26,588	2					
3												3					
4							Allocation from Home Office				13,602	4					
5							Offset of Interest Income				(2,392)	5					
	Working Capital																
6												6					
7												7					
8												8					
9	TOTAL Facility Related						\$ 1,080,000	\$ 1,066,405			\$ 115,170	9					
	B. Non-Facility Related*																
10												10					
11												11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$	14					
15	TOTALS (line 9+line14)						\$ 1,080,000	\$ 1,066,405			\$ 115,170	15					

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

IMPORTANT NOTICE

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

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

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

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Shelbyville Rehabilitation & Health Care Cente COUNTY Shelby

FACILITY IDPH LICENSE NUMBER 0047563

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

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

A. Summary of Real Estate Tax Cos

Enter the tax index number and real estate tax assessed for 2005 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200!

(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. 1812-13-01-103-005	Nursing Home	\$ 31,442.00	\$ 31,442.00
2. _____	Home Office Allocation	\$ _____	\$ 1,309.00
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>31,442.00</u>	\$ <u>32,751.00</u>

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct 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 hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. Tax Bills

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 20C tax bill which is normally paid during 2006

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 16,099 B. General Construction Type: Exterior Brick Frame Wood 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: N/A 2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A 4. Dates Incurred: N/A

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>80,150</u>	<u>2005</u>	<u>\$ 47,250</u>	1
2					2
3	TOTALS	80,150		\$ 47,250	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shelbyville Rehabilitation & Health Care Center

0047563

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	80		2005	1971	\$ 855,750	\$	25	\$ 34,230	\$ 34,230	\$ 51,345	4
5											5
6											6
7	Home Office										7
8	Allocation		2006		7,899			346	346	346	8
	Improvement Type**										
9	Original Land Improvements		2005		15,000		15	1,000	1,000	1,500	9
10	Sidewalks		2006		6,365		15	212	212	212	10
11											11
12	Land Improvement Booked					1,248			(1,248)		12
13	Building Booked					34,256			(34,256)		13
14											14
15	2006 Home Office allocation - Land & Land Improvements		2006		457			42	42	42	15
16	2006 Home Office allocation - Buildings Improvements		2006		13			1	1	1	16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shelbyville Rehabilitation & Health Care Center

0047563

Report Period Beginning:

01/01/06 Ending:

12/31/06

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)	\$ 885,484	\$ 35,504		\$ 35,831	\$ 327	\$ 53,446	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Shelbyville Rehabilitation & Health Care Center # 0047563 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	\$ 167,600	\$ 27,364	\$ 25,010	\$ (2,354)	3-7 Years	\$ 37,513	71
72	Current Year Purchases	20,729		1,630	1,630	3-5 Years	1,630	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			4,022	4,022			74
75	TOTALS	\$ 188,329	\$ 27,364	\$ 30,662	\$ 3,298		\$ 39,143	75

D. Vehicle Depreciation (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,121,063	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 62,868	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 66,493	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 3,625	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 92,589	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	N/A	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6			<u>Home Office Allocation</u>		<u>596</u>			6
7	TOTAL				\$ 596			7

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.	<u>/2007</u>	\$ _____
13.	<u>/2008</u>	\$ _____
14.	<u>/2009</u>	\$ _____

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: \$ 12,094 Description: Copier \$2,364; Dishwasher \$826; HO Allocation \$390; Nursing Equip \$8,514;
(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

* 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.

Facility Name & ID Number Shelbyville Rehabilitation & Health Care Center # 0047563 Report Period Beginning: 01/01/06 Ending: 12/31/06

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>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>	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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	\$	331	\$ 26,420	\$	331	\$ 26,420	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		62	5,342		62	5,342	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3) (7)	hrs		619	47,961	313	619	48,274	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39(3)			35	2,760		35	2,760	12
13	Other (specify):									13
14	TOTAL			\$	1,047	\$ 82,483	\$ 313	1,047	\$ 82,796	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shelbyville Rehabilitation & Health Care Center# 0047563Report Period Beginning: 01/01/06

Ending:

12/31/06

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/06

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 450	\$ 450	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>None</u>)	384,705	384,705	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	5,446	5,446	7
8	Accounts Receivable (owners or related parties)	3,600	3,600	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 394,201	\$ 394,201	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	924,365	932,264	14
15	Leasehold Improvements, at Historical Cost		470	15
16	Equipment, at Historical Cost	188,329	188,329	16
17	Accumulated Depreciation (book methods)	(75,856)	(92,589)	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>Security Deposit</u>	6,366	6,366	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,043,204	\$ 1,034,840	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,437,405	\$ 1,429,041	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 342,989	\$ 342,989	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	14,800	14,800	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,543	4,543	31
32	Accrued Real Estate Taxes(Sch.IX-B)	31,500	31,500	32
33	Accrued Interest Payable	11,088	11,088	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Accrued Expenses</u>	11,920	11,920	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 416,840	\$ 416,840	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	169,689	169,689	40
41	Bonds Payable	896,716	896,716	41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,066,405	\$ 1,066,405	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,483,245	\$ 1,483,245	46
47	TOTAL EQUITY (page 18, line 24)	\$ (45,840)	\$ (54,204)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,437,405	\$ 1,429,041	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 66,731	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 66,731	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(112,574)	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) Rounding	3	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (112,571)	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)	\$ (45,840)	24 *

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
		Revenue	Amount
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 1,229,434	1
2	Discounts and Allowances for all Levels	24,365	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,253,799	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	118,485	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 118,485	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants	42,728	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	250	13
14	Non-Patient Meals	3,466	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	56,160	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	13,918	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 116,522	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,392	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,392	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc. Income	883	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 883	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,492,081	30

		2	
		Expenses	Amount
A. Operating Expenses			
31	General Services	348,451	31
32	Health Care	678,593	32
33	General Administration	258,309	33
B. Capital Expense			
34	Ownership	210,032	34
C. Ancillary Expense			
35	Special Cost Centers	65,470	35
36	Provider Participation Fee	43,800	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,604,655	40
41	Income before Income Taxes (line 30 minus line 40)**	(112,574)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (112,574)	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.
This entity is a cash-basis taxpayer.

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

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

Facility Name & ID Number Shelbyville Rehabilitation & Health Care Center

0047563

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	\$ 50,787	\$ 24.42	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,945	4,016	73,772	18.37	3
4	Licensed Practical Nurses	9,291	9,497	147,810	15.56	4
5	CNAs & Orderlies	23,102	23,243	197,619	8.50	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,847	1,911	18,836	9.86	9
10	Activity Assistants	136	136	1,107	8.14	10
11	Social Service Workers	2,064	2,064	25,563	12.39	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	26,310	12.65	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,273	9,281	73,678	7.94	15
16	Dishwashers					16
17	Maintenance Workers	2,055	2,055	25,223	12.27	17
18	Housekeepers	5,621	5,629	37,202	6.61	18
19	Laundry	1,901	1,955	13,448	6.88	19
20	Administrator	2,072	2,072	48,094	23.21	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,484	1,484	15,061	10.15	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	66,951	67,503	\$ 754,510 *	\$ 11.18	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	6,000	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	682	10,3	38
39	Pharmacist Consultant				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)		\$ 6,682		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ N/A		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Shelbyville Rehabilitation & Health Care Center# 0047563Report Period Beginning: 01/01/06Ending: 12/31/06**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 3-5 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 4,291 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. \$ 43,800
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. \$ 4,119 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 3,466
- (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 & Co. The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit currently in progress
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT