

Facility Name & ID Number Sheldon Health Care Center

0046573 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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	31	Intermediate (ICF)	31	11,315	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	31	TOTALS	31	11,315	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			
		2 Medicaid Recipient	3 Private Pay	4 Other	
8	SNF				8
9	SNF/PED				9
10	ICF	9,258	423		9,681
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	9,258	423		9,681

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.56%

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)

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 1/1/04

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

YES Date 1/1/04 NO

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

YES NO If YES, enter number of beds certified NA and days of care provided NA

Medicare Intermediary N/A

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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheldon Health Care Center # 0046573 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	73,480	10,231	840	84,551		84,551	688	85,239		1
2	Food Purchase		58,019		58,019		58,019	(7,411)	50,608		2
3	Housekeeping	69,744	7,523		77,267		77,267	30	77,297		3
4	Laundry	2,572	2,796	306	5,674		5,674		5,674		4
5	Heat and Other Utilities			30,885	30,885		30,885	(2,949)	27,936		5
6	Maintenance	17,651	20,990	2,523	41,164		41,164	1,751	42,915		6
7	Other (specify):* Home Ofc. Benefit							276	276		7
8	TOTAL General Services	163,447	99,559	34,554	297,560		297,560	(7,615)	289,945		8
	B. Health Care and Programs										
9	Medical Director			3,900	3,900		3,900		3,900		9
10	Nursing and Medical Records	350,931	17,203	500	368,634		368,634	2,272	370,906		10
10a	Therapy							229	229		10a
11	Activities	28,095	795	5,263	34,153		34,153		34,153		11
12	Social Services										12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Ofc. Benefit							769	769		15
16	TOTAL Health Care and Programs	379,026	17,998	9,663	406,687		406,687	3,270	409,957		16
	C. General Administration										
17	Administrative	37,891		57,000	94,891		94,891	(13,155)	81,736		17
18	Directors Fees										18
19	Professional Services			7,610	7,610		7,610	4,239	11,849		19
20	Dues, Fees, Subscriptions & Promotions			3,587	3,587		3,587	1,536	5,123		20
21	Clerical & General Office Expenses		5,285	5,110	10,395		10,395	11,358	21,753		21
22	Employee Benefits & Payroll Taxes			106,311	106,311		106,311	6,873	113,184		22
23	Inservice Training & Education			161	161		161	88	249		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			5,225	5,225		5,225	1,035	6,260		25
26	Insurance-Prop.Liab.Malpractice			7,347	7,347		7,347	521	7,868		26
27	Other (specify):* Home Ofc. Benefit							1,933	1,933		27
28	TOTAL General Administration	37,891	5,285	192,351	235,527		235,527	14,428	249,955		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	580,364	122,842	236,568	939,774		939,774	10,083	949,857		29

SEE ACCOUNTANTS' COMPILATION REPORT

*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.

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7**	8		
30	Depreciation			47,712	47,712		47,712	1,008	48,720		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			28,742	28,742		28,742	9,651	38,393		32
33	Real Estate Taxes			3,557	3,557		3,557	(404)	3,153		33
34	Rent-Facility & Grounds							306	306		34
35	Rent-Equipment & Vehicles			1,015	1,015		1,015	161	1,176		35
36	Other (specify):*										36
37	TOTAL Ownership			81,026	81,026		81,026	10,722	91,748		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers										39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			16,973	16,973		16,973		16,973		42
43	Other (specify):* Nonallowable Cost			44,907	44,907		44,907	(44,907)			43
44	TOTAL Special Cost Centers			61,880	61,880		61,880	(44,907)	16,973		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	580,364	122,842	379,474	1,082,680		1,082,680	(24,102)	1,058,578		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

Facility Name & ID Number Sheldon Health Care Center

0046573

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	(4,079)	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	281	30		9
10	Interest and Other Investment Income	(1,001)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(334)	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	(73)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(35,025)	43		24
25	Fund Raising, Advertising and Promotional	(2,349)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See PG 5A	(14,861)	var		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (57,441)		\$	30

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)	33,339	var	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 33,339		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (24,102)		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

BHF USE ONLY					
48		49		50	
				51	
					52

SEE ACCOUNTANTS' COMPILATION REPORT

Sheldon Health Care Center

ID# 0046573

Report Period Beginning: 01/01/06

Ending: 12/31/06

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Nonallowable marketing events	\$ (75)	43	1
2	Offset meal revenue	(2,340)	2	2
3	Special events	(2,972)	43	3
4	Misc. Revenue	(835)	21	4
5	Nonallowable Architecture Fees	(215)	19	5
6	Disallowed Apartment % of Real Estate Taxes	(720)	33	6
7	Disallow Apartment % of Depreciation	(1,968)	30	7
8	Disallow Apartment % of Utilities	(3,088)	5	8
9	Nonallowable Travel Expense	(2,648)	24	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
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31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(14,861)		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		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%	\$ 688	\$ 688	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	34	34	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	30	30	3
4	V							4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	128	128	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	1,751	1,751	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	276	276	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	2,489	2,489	8
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	229	229	9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	769	769	10
11	V	17 Administrative	57,000	Petersen Health Care, Inc.	100.00%	6,785	(50,215)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	2,971	2,971	12
13	V	20 Due, Fees, Subs & Promos		Petersen Health Care, Inc.	100.00%	291	291	13
14	Total		\$ 57,000			\$ 16,441	\$ * (40,559)	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	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	21 Clerical & General Office	\$	Petersen Health Care, Inc.	100.00%	\$ 10,938	\$	10,938	15
16	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	88		88	16
17	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	2,648		2,648	17
18	V	25 Other Admin. Staff Transport		Petersen Health Care, Inc.	100.00%	704		704	18
19	V	26 Insurance-Prop.Liab.Malpractice		Petersen Health Care, Inc.	100.00%	521		521	19
20	V	27 Mgmt Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,933		1,933	20
21	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	2,697		2,697	21
22	V	32 Interest		Petersen Health Care, Inc.	100.00%	1,498		1,498	22
23	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	316		316	23
24	V	34 Rent - Facility & Grounds		Petersen Health Care, Inc.	100.00%	306		306	24
25	V	35 Rent - Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	161		161	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		\$			\$ 21,810	\$ *	21,810	39

* 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	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	5 Utilities	\$	Petersen Health Enterprises	0.00%	\$ 11	\$	11	15
16	V	17 Administrative		Petersen Health Enterprises	0.00%	37,060		37,060	16
17	V	19 Professional Services		Petersen Health Enterprises	0.00%	1,483		1,483	17
18	V	20 Dues, Fees, Subs & Promotions		Petersen Health Enterprises	0.00%	1,245		1,245	18
19	V	21 Clerical & General Office		Petersen Health Enterprises	0.00%	1,037		1,037	19
20	V	22 Employee Benefits		Petersen Health Enterprises	0.00%	1,767		1,767	20
21	V	25 Other Admin. Staff Transport		Petersen Health Enterprises	0.00%	331		331	21
22	V	32 Interest		Petersen Health Enterprises	0.00%	9,154		9,154	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 52,088	\$ *	52,088	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Sheldon Health Care Center

0046573

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	70.00	See Schedule 7A	0.42	0.85	Salary	\$ 6,785	L17,C7	1
2	Jifi C. Jacob	Owner	Administrative	10.00	See Schedule 7B	7	13.23	Salary	10,848	L17,C7	2
3	Cindy S. White	Owner	Administrative	10.00	See Schedule 7B	7	13.23	Salary	12,513	L17,C7	3
4	Jacque Whitley	Owner	Administrative	10.00	See Schedule 7B	7	13.23	Salary	13,698	L17,C7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 43,844		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

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0046573

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01/01/06

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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

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

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

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	\$ 80,967	9,681	\$ 688	1
2	2	Food	Patient Days	1,141,463	56	3,989		9,681	34	2
3	3	Housekeeping	Patient Days	1,141,463	56	3,589		9,681	30	3
4										4
5	5	Utilities	Patient Days	1,141,463	56	15,054		9,681	128	5
6	6	Maintenance	Patient Days	1,141,463	56	206,416	110,513	9,681	1,751	6
7	7	Mgmt. Allocation of Benefits	Patient Days	1,141,463	56	32,526		9,681	276	7
8	10	Nursing and Medical Records	Patient Days	1,141,463	56	293,462	289,197	9,681	2,489	8
9	10A	Therapy	Patient Days	1,141,463	56	26,945		9,681	229	9
10	15	Mgmt. Allocation of Benefits	Patient Days	1,141,463	56	90,724		9,681	769	10
11	17	Administrative	Patient Days	1,141,463	56	800,000	800,000	9,681	6,785	11
12	19	Professional Services	Patient Days	1,141,463	56	350,361		9,681	2,971	12
13	20	Due, Fees, Subs & Promos	Patient Days	1,141,463	56	34,325		9,681	291	13
14	21	Clerical & General Office	Patient Days	1,141,463	56	1,289,623	954,322	9,681	10,938	14
15	23	Inservice Training & Education	Patient Days	1,141,463	56	10,426		9,681	88	15
16	24	Travel and Seminar	Patient Days	1,141,463	56	312,259		9,681	2,648	16
17	25	Other Admin. Staff Transport	Patient Days	1,141,463	56	83,062		9,681	704	17
18	26	Insurance-Prop.Liab.Malpractice	Patient Days	1,141,463	56	61,457		9,681	521	18
19	27	Mgmt Allocation of Benefits	Patient Days	1,141,463	56	227,912		9,681	1,933	19
20	30	Depreciation	Patient Days	1,141,463	56	317,964		9,681	2,697	20
21	32	Interest	Patient Days	1,141,463	56	176,614		9,681	1,498	21
22	33	Real Estate Taxes	Patient Days	1,141,463	56	37,282		9,681	316	22
23	34	Rent - Facility & Grounds	Patient Days	1,141,463	56	36,133		9,681	306	23
24	35	Rent - Equipment & Vehicles	Patient Days	1,141,463	56	18,933		9,681	161	24
25	TOTALS					\$ 4,510,235	\$ 2,234,999		\$ 38,251	25

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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

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

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6		
1	5	Utilities	Patient Days	73,177	5	\$ 85	\$ 9,681	\$ 11	1	
2	17	Administrative	Patient Days	73,177	5	280,132	280,132	9,681	37,060	2
3	19	Professional Services	Patient Days	73,177	5	11,209	9,681		1,483	3
4	20	Dues, Fees, Subs & Promos	Patient Days	73,177	5	9,408	9,681		1,245	4
5	21	Clerical & General Office	Patient Days	73,177	5	7,841	9,681		1,037	5
6	22	Employee Benefits	Patient Days	73,177	5	13,355	9,681		1,767	6
7	25	Other Admin. Staff Transport	Patient Days	73,177	5	2,500	9,681		331	7
8	32	Interest	Patient Days	73,177	5	69,197	9,681		9,154	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 393,727	\$ 280,132		\$ 52,088	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Sheldon Health Care Center

0046573

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	2	3	4	5	6	7	8	9	10											
										Name of Lender	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	Sheldon Meadows		X	Mortgage	\$5,805.00	02/05/04	\$ 500,000	\$ 388,193	01/05/14	7.0000	\$ 28,742	1								
2												2								
3							Home Office Allocation				10,652	3								
4							Offset Interest Income				(1,001)	4								
5												5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related				\$5,805.00		\$ 500,000	\$ 388,193			\$ 38,393	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 500,000	\$ 388,193			\$ 38,393	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.)

Facility Name & ID Number **Sheldon Health Care Center**

0046573

Report Period Beginning:

01/01/06

Ending:

12/31/06

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2005 report.				\$	10,733 1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		2005		\$	7,091 2
3. Under or (over) accrual (line 2 minus line 1).				\$	(3,642) 3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	7,200 4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			Home Office Allocation & Nonallowable Real Estate Tax	\$	(405) 3,153 7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2001	_____	8	FOR BHF USE ONLY	
	2002	_____	9	13	FROM R. E. TAX STATEMENT FOR 2005 \$ 13
	2003	6,161	10	14	PLUS APPEAL COST FROM LINE 5 \$ 14
	2004	7,309	11	15	LESS REFUND FROM LINE 6 \$ 15
	2005	7,091	12	16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
Accrual based on prior year tax bill.					
Home Office Allocation \$316					
Nonallowable Real Estate Tax (\$721)					

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

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, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sheldon Health Care Center COUNTY Iroquois

FACILITY IDPH LICENSE NUMBER 0046573

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 2005 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 2005.

(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-C-27-02-253-001</u>	<u>Nursing Home</u>	\$ <u>7,091.00</u>	\$ <u>6,371.00</u>
2. _____	<u>Home Office Allocation</u>	\$ _____	\$ <u>316.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>7,091.00</u>	\$ <u>6,687.00</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheldon Health Care Center

0046573

Report Period Beginning:

01/01/06

Ending:

12/31/06

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 11,605 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).

10 apartments are maintained on the nursing home grounds.

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>Resident Care</u>		<u>2004</u>	<u>\$ 29,249</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 29,249	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheldon Health Care Center

0046573

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	31	2004		\$ 443,250	\$	25	\$ 17,730	\$ 17,730	\$ 47,280	4
5										5
6		Allocated	2006	5,774			253	253	253	6
7		from home								7
8		office								8
Improvement Type**										
9	Remodeling		2004	1,175		30	39	39	94	9
10	Landscaping Improvements		2005	1,375		15	92	92	130	10
11	Living room, lobby, hallway paint and border		2005	3,000		30	100	100	158	11
12	Flooring		2006	899		15	30	30	30	12
13	Roof		2006	2,015		25	40	40	40	13
14	Garage Door		2006	693		15	23	23	23	14
15	Watchmate		2006	6,435		5	644	644	644	15
16	Land Improvement Booked		2006		92			(92)		16
17	Building Booked		2006		19,700			(19,700)		17
18	Building Improvement Booked		2006		438			(438)		18
19										19
20										20
21										21
22										22
23	Allocated from home office -Land and Improvements		2006	334			31	31	31	23
24	Allocated from home office-Leasehold Improvements		2006	9			1	1	1	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

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)	\$	\$ 464,959		\$ 18,983	\$ (1,247)	\$ 48,684	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Sheldon Health Care Center

0046573

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	\$ 186,919	\$ 27,482	\$ 27,068	\$ (414)	3-10	\$ 64,227	71
72	Current Year Purchases	3,908		257	257	5-10	257	72
73	Fully Depreciated Assets							73
74	Allocation from Home Office			2,412	2,412			74
75	TOTALS	\$ 190,827	\$ 27,482	\$ 29,737	\$ 2,255		\$ 64,484	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77		N/A								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)	\$ 685,035	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 47,712	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 48,720	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,008	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 113,168	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	Apartments & Land - 2004	\$ 52,500	\$	\$ 5,828	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 52,500	\$	\$ 5,828	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? YES NO

If NO, see instructions.

	1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:			\$			3
4	Additions						4
5	Home Office Allocation			306			5
6							6
7	TOTAL			\$ 306			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: \$ 1,176 Description: Nursing Equipment \$1,015; Home Office Allocation \$161.

(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					18
19	N/A				19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____
Ending _____

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

	Fiscal Year Ending	Annual Rent
12.	<u>/2007</u>	\$ _____
13.	<u>/2008</u>	\$ _____
14.	<u>/2009</u>	\$ _____

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$ _____

D. NUMBER OF CNAs TRAINED

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

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

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
 - (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
- 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		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist	N/A	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							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									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	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 Sheldon Health Care Center

0046573

Report 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	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 500	\$ 500	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>None</u>)	135,207	135,207	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	200	200	6
7	Other Prepaid Expenses	8,195	8,195	7
8	Accounts Receivable (owners or related parties)	26,310	26,310	8
9	Other(specify): <u>Employee Advances</u>	1,350	1,350	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 171,762	\$ 171,762	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	33,875	29,249	13
14	Buildings, at Historical Cost	506,717	464,959	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	190,827	190,827	16
17	Accumulated Depreciation (book methods)	(126,481)	(113,168)	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 Assets</u>		46,810	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 604,938	\$ 618,677	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 776,700	\$ 790,439	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 252,240	\$ 252,240	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	44,302	44,302	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,404	1,404	31
32	Accrued Real Estate Taxes(Sch.IX-B)	7,200	7,200	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Withholdings</u>	9,405	9,405	36
37	<u>Accrued Expenses</u>	320,920	320,920	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 635,471	\$ 635,471	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	388,193	388,193	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	_____			43
44	_____			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 388,193	\$ 388,193	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,023,664	\$ 1,023,664	46
47	TOTAL EQUITY(page 18, line 24)	\$ (246,964)	\$ (233,225)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 776,700	\$ 790,439	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (113,849)	1
2	Restatements (describe):		2
3	Post Cost Report Audit Adjustments	(41,945)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (155,794)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(91,170)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (91,170)	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)	\$ (246,964)	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	\$ 971,049	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 971,049	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,340	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,340	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,001	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,001	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous	135	28
28a	Insurance Liability	16,985	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 17,120	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 991,510	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	297,560	31
32	Health Care	406,687	32
33	General Administration	235,527	33
	B. Capital Expense		
34	Ownership	81,026	34
	C. Ancillary Expense		
35	Special Cost Centers	44,907	35
36	Provider Participation Fee	16,973	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,082,680	40
41	Income before Income Taxes (line 30 minus line 40)**	(91,170)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (91,170)	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 Sheldon Health Care Center

0046573

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	\$ 46,631	\$ 22.42	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,955	2,040	42,307	20.74	3
4	Licensed Practical Nurses	6,626	7,028	128,302	18.26	4
5	CNAs & Orderlies	14,010	14,848	133,691	9.00	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,016	2,072	25,759	12.43	9
10	Activity Assistants	332	332	2,201	6.63	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	20,388	9.80	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,803	6,253	53,092	8.49	15
16	Dishwashers					16
17	Maintenance Workers	1,483	1,483	17,651	11.90	17
18	Housekeepers	8,146	8,525	69,744	8.18	18
19	Laundry	1,260	1,260	2,572	2.04	19
20	Administrator	2,080	2,080	37,891	18.22	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					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>	21	21	135	6.43	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	47,891	50,102	\$ 580,364 *	\$ 11.58	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	16	\$ 840	1(3)	35
36	Medical Director	Monthly	3,900	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	500	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)	16	\$ 5,240		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. 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	
<u>Tina Gooding</u>	<u>Administrator</u>	<u>0</u>	\$ <u>37,891</u>	<u>Workers' Compensation Insurance</u>	\$ <u>17,567</u>	<u>IDPH License Fee</u>	\$ <u>2,316</u>	
				<u>Unemployment Compensation Insurance</u>	<u>15,050</u>	<u>Advertising: Employee Recruitment</u>	<u>509</u>	
				<u>FICA Taxes</u>	<u>42,298</u>	<u>Health Care Worker Background Check</u>	<u>390</u>	
				<u>Employee Health Insurance</u>	<u>30,873</u>	(Indicate # of checks performed <u>39</u>)		
				<u>Employee Meals</u>	<u>5,106</u>	<u>Patient Background Checks</u>		
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Miscellaneous Dues & Subscriptions</u>	<u>372</u>	
				<u>Employee Retirement</u>	<u>865</u>	<u>Allocated from Home Office</u>	<u>1,536</u>	
				<u>Employee Relations</u>	<u>1,425</u>			
TOTAL (agree to Schedule V, line 17, col. 1)			\$ <u>37,891</u>					
(List each licensed administrator separately.)								
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
<u>Management Fee (eliminated in column 7)</u>			\$ <u>57,000</u>				<u>Out-of-State Travel</u>	\$
							<u>In-State Travel</u>	
							<u>N/A</u>	
							<u>Seminar Expense</u>	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ <u>57,000</u>				<u>Entertainment Expense</u>	()
(Attach a copy of any management service agreement)							TOTAL (agree to Sch. V, line 20, col. 8)	\$ <u>5,123</u>
C. Professional Services				TOTAL			TOTAL	
Vendor/Payee	Type			Description	Line #	Amount		
<u>Altschuler, Melvoin & Glasser, LLP</u>	<u>Accounting</u>	\$ <u>4,250</u>						
<u>Mediacom</u>	<u>Computer Services</u>	<u>720</u>						
<u>LTC Solutions</u>	<u>Computer Services</u>	<u>2,640</u>		<u>N/A</u>				
TOTAL (agree to Schedule V, line 19, column 3)			\$ <u>7,610</u>					
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Sheldon Health Care Center
Provider Number - 0046573
FYE: 12/31/2006

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Total (agree to Schedule V, line 19, column 3) 7,610

Allocated from Home Office

Other Professional Fees	2,932	
Legal	39	
Other Professional Fees - PHC	927	
Legal - PHC	556	
Home Office Architect Fee Offset, per Sch VI	<u>(215)</u>	<u>4,239</u>

Total (agree to Schedule V, line 19, column 8) 11,849

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	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4	N/A												
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 Sheldon Health Care Center

0046573

Report Period Beginning:

01/01/06

Ending:

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? 7 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 967 Line 10,2
- (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. \$ 16,973
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.

SEE ACCOUNTANTS' COMPILATION REPORT

- (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. \$ 5,106 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,340
- (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? Yes
- 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? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (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