

Facility Name & ID Number Rochelle Rehab & Healthcare Center

0048561 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	50	Skilled (SNF)	50	18,250	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	50	TOTALS	50	18,250	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	5,077	4,666	2,918	12,661	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,077	4,666	2,918	12,661	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.38%

D. How many bed-hold days during this year were paid by the Department? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 10/31/2006

J. Was the facility purchased or leased after January 1, 1978?
YES Date 10/31/2006 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 50 and days of care provided 2,918

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number Rochelle Rehab & Healthcare Center # 0048561 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	102,146	7,707	1,611	111,464		111,464	1,059	112,523		1
2	Food Purchase		65,662		65,662		65,662	(195)	65,467		2
3	Housekeeping	90,794	11,464		102,258		102,258	17	102,275		3
4	Laundry	6,365	12,195		18,560		18,560	1	18,561		4
5	Heat and Other Utilities			58,995	58,995		58,995	181	59,176		5
6	Maintenance	35,459	11,798	16,771	64,028		64,028	1,549	65,577		6
7	Other (specify):* Home Off. Ben. All.							483	483		7
8	TOTAL General Services	234,764	108,826	77,377	420,967		420,967	3,095	424,062		8
	B. Health Care and Programs										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	593,468	31,904	54,629	680,001		680,001	2,814	682,815		10
10a	Therapy	61,588		66,221	127,809		127,809		127,809		10a
11	Activities	21,257	85	1,284	22,626		22,626		22,626		11
12	Social Services	36,958			36,958		36,958		36,958		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.							623	623		15
16	TOTAL Health Care and Programs	713,271	31,989	140,134	885,394		885,394	3,437	888,831		16
	C. General Administration										
17	Administrative	55,495		41,000	96,495		96,495	(33,113)	63,382		17
18	Directors Fees										18
19	Professional Services			12,912	12,912		12,912	2,889	15,801		19
20	Dues, Fees, Subscriptions & Promotions			9,980	9,980		9,980	194	10,174		20
21	Clerical & General Office Expenses	4,114	3,553	7,409	15,076		15,076	19,556	34,632		21
22	Employee Benefits & Payroll Taxes			127,005	127,005		127,005		127,005		22
23	Inservice Training & Education			835	835		835	228	1,063		23
24	Travel and Seminar							329	329		24
25	Other Admin. Staff Transportation			3,329	3,329		3,329	1,261	4,590		25
26	Insurance-Prop.Liab.Malpractice			6,331	6,331		6,331	561	6,892		26
27	Other (specify):* Home Off. Ben. All.							5,135	5,135		27
28	TOTAL General Administration	59,609	3,553	208,801	271,963		271,963	(2,960)	269,003		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,007,644	144,368	426,312	1,578,324		1,578,324	3,572	1,581,896		29

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

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

Facility Name & ID Number Rochelle Rehab & Healthcare Center

#0048561

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			150,910	150,910		150,910	(31,501)	119,409			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			169,166	169,166		169,166	4,594	173,760			32
33	Real Estate Taxes			18,829	18,829		18,829	414	19,243			33
34	Rent-Facility & Grounds							25	25			34
35	Rent-Equipment & Vehicles			2,958	2,958		2,958	334	3,292			35
36	Other (specify):*											36
37	TOTAL Ownership			341,863	341,863		341,863	(26,134)	315,729			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		71,034		71,034		71,034		71,034			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			29,700	29,700		29,700		29,700			42
43	Other (specify):* Non-allowable Cost	21,323	400	55,482	77,205		77,205	(77,205)				43
44	TOTAL Special Cost Centers	21,323	71,434	85,182	177,939		177,939	(77,205)	100,734			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,028,967	215,802	853,357	2,098,126		2,098,126	(99,767)	1,998,359			45

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

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(232)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,043)	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	(32,966)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(93)	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	(88)	43		18
19	Entertainment				19
20	Contributions	(100)	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	(30,291)	43		24
25	Fund Raising, Advertising and Promotional	(25,511)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule <u>See Pg. 5A</u>	(15,367)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (110,691)		\$	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)	10,924	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 10,924		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (99,767)		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

Rochelle Rehab & Healthcare Center

ID# 0048561

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (12,448)	43	1
2	X-Rays-Part A	(325)	43	2
3	Resident Flower	(418)	10	3
4	Offset Miscellaneous Office Supplies Revenue	(18)	21	4
5	Offset Chamber of Commerce Dues	(270)	20	5
6	Disallowed Special Events	(1,888)	43	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(15,367)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rochelle Rehab & Healthcare Center# 0048561

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	1,059	0	0	0	0	0	0	0	0	0	1,059	1
2	Food Purchase	(232)	37	0	0	0	0	0	0	0	0	0	(195)	2
3	Housekeeping	0	12	0	5	0	0	0	0	0	0	0	17	3
4	Laundry	0	1	0	0	0	0	0	0	0	0	0	1	4
5	Heat and Other Utilities	0	181	0	0	0	0	0	0	0	0	0	181	5
6	Maintenance	0	1,476	0	73	0	0	0	0	0	0	0	1,549	6
7	Other (specify):*	0	483	0	0	0	0	0	0	0	0	0	483	7
8	TOTAL General Services	(232)	3,249	0	78	0	3,095	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	(418)	2,801	0	13	0	0	0	0	0	0	0	2,396	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	623	0	0	0	0	0	0	0	0	0	623	15
16	TOTAL Health Care and Programs	(418)	3,424	0	13	0	3,019	16						
	C. General Administration													
17	Administrative	0	(33,113)	0	0	0	0	0	0	0	0	0	(33,113)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	2,141	0	748	0	0	0	0	0	0	0	2,889	19
20	Fees, Subscriptions & Promotions	(270)	0	464	0	0	0	0	0	0	0	0	194	20
21	Clerical & General Office Expenses	(18)	0	17,959	1,615	0	0	0	0	0	0	0	19,556	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	207	21	0	0	0	0	0	0	0	228	23
24	Travel and Seminar	0	0	329	0	0	0	0	0	0	0	0	329	24
25	Other Admin. Staff Transportation	0	0	1,191	70	0	0	0	0	0	0	0	1,261	25
26	Insurance-Prop.Liab.Malpractice	0	0	485	76	0	0	0	0	0	0	0	561	26
27	Other (specify):*	0	0	5,135	0	0	0	0	0	0	0	0	5,135	27
28	TOTAL General Administration	(288)	(30,972)	25,770	2,530	0	(2,960)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(938)	(24,299)	25,770	2,621	0	3,154	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rochelle Rehab & Healthcare Center # 0048561 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(32,966)	0	1,258	207	0	0	0	0	0	0	0	(31,501)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	2,186	2,408	0	0	0	0	0	0	0	4,594	32
33	Real Estate Taxes	0	0	414	0	0	0	0	0	0	0	0	414	33
34	Rent-Facility & Grounds	0	0	25	0	0	0	0	0	0	0	0	25	34
35	Rent-Equipment & Vehicles	0	0	334	0	0	0	0	0	0	0	0	334	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(32,966)	0	4,217	2,615	0	(26,134)	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):*	(76,787)	0	0	0	0	0	0	0	0	0	0	(76,787)	43
44	TOTAL Special Cost Centers	(76,787)	0	0	0	0	0	0	0	0	0	0	(76,787)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(110,691)	(24,299)	29,987	5,236	0	(99,767)	45						

Facility Name & ID Number

Rochelle Rehab & Healthcare Center

0048561

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark Petersen	100	See Attached Schedule 6E		See Attached Sch 6E		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 1,059	\$ 1,059	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	37	37	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	12	12	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	1	1	4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	181	181	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	1,476	1,476	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	483	483	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	2,801	2,801	8
9	V	11 Activities		Petersen Health Care, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	623	623	10
11	V	17 Administrative	41,000	Petersen Health Care, Inc.	100.00%	7,887	(33,113)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	2,141	2,141	12
13	V							13
14	Total		\$ 41,000			\$ 16,701	\$ * (24,299)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	20 Dues, Fees, Subs and Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 464	\$	464	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	17,959		17,959	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	207		207	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	329		329	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	1,191		1,191	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	485		485	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	5,135		5,135	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	1,258		1,258	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	2,186		2,186	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	414		414	24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	25		25	25
26	V	35 Rent-Equipment and Vehicles		Petersen Health Care, Inc.	100.00%	334		334	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		\$			\$ 29,987	\$ *	29,987	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 <u>Dietary</u>	\$	<u>Petersen Companies, LLC</u>	100.00%	\$ 0	\$	0	15
16	V	2 <u>Food</u>		<u>Petersen Companies, LLC</u>	100.00%	0		0	16
17	V	3 <u>Housekeeping</u>		<u>Petersen Companies, LLC</u>	100.00%	5		5	17
18	V	4 <u>Laundry</u>		<u>Petersen Companies, LLC</u>	100.00%	0		0	18
19	V	5 <u>Utilities</u>		<u>Petersen Companies, LLC</u>	100.00%	0		0	19
20	V	6 <u>Maintenance</u>		<u>Petersen Companies, LLC</u>	100.00%	73		73	20
21	V	7 <u>Mgmt. Allocation of Benefits</u>		<u>Petersen Companies, LLC</u>	100.00%	0		0	21
22	V	10 <u>Nursing and Medical Records</u>		<u>Petersen Companies, LLC</u>	100.00%	13		13	22
23	V	10A <u>Therapy</u>		<u>Petersen Companies, LLC</u>	100.00%	0		0	23
24	V	15 <u>Mgmt. Allocation of Benefits</u>		<u>Petersen Companies, LLC</u>	100.00%	0		0	24
25	V	17 <u>Administrative</u>		<u>Petersen Companies, LLC</u>	100.00%	0		0	25
26	V	19 <u>Professional Services</u>		<u>Petersen Companies, LLC</u>	100.00%	748		748	26
27	V	20 <u>Dues, Fees, Subs and Promotions</u>		<u>Petersen Companies, LLC</u>	100.00%	0		0	27
28	V	21 <u>Clerical and General Office</u>		<u>Petersen Companies, LLC</u>	100.00%	1,615		1,615	28
29	V	23 <u>Inservice Training and Education</u>		<u>Petersen Companies, LLC</u>	100.00%	21		21	29
30	V	24 <u>Travel and Seminar</u>		<u>Petersen Companies, LLC</u>	100.00%	0		0	30
31	V	25 <u>Other Admin. Staff Transportation</u>		<u>Petersen Companies, LLC</u>	100.00%	70		70	31
32	V	26 <u>Insurance-Prop./Liab/Malpractice</u>		<u>Petersen Companies, LLC</u>	100.00%	76		76	32
33	V	27 <u>Mgmt. Allocation of Benefits</u>		<u>Petersen Companies, LLC</u>	100.00%	0		0	33
34	V	30 <u>Depreciation</u>		<u>Petersen Companies, LLC</u>	100.00%	207		207	34
35	V	32 <u>Interest</u>		<u>Petersen Companies, LLC</u>	100.00%	2,408		2,408	35
36	V	33 <u>Real Estate Taxes</u>		<u>Petersen Companies, LLC</u>	100.00%	0		0	36
37	V	34 <u>Rent-Facility and Grounds</u>		<u>Petersen Companies, LLC</u>	100.00%	0		0	37
38	V	35 <u>Rent-Equipment and Vehicles</u>		<u>Petersen Companies, LLC</u>	100.00%	0		0	38
39	Total		\$			\$ 5,236	\$ *	5,236	39

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

Facility Name & ID Number Rochelle Rehab & Healthcare Center # 0048561 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Petersen	President	Administrative	100.00	See Schedule 7A	0.52	0.94	Salary	\$ 7,887	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	\$ 7,887		13

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

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

Facility Name & ID Number Rochelle Rehab & Healthcare Center# 0048561

Report Period Beginning:

01/01/2007Ending: 12/31/2007

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization

Petersen Health Care, Inc.

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309) 691-8113

Fax Number

(309) 691-8622

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,316,550	66	\$ 110,171	\$ 109,587	12,661	\$ 1,059	1
2	2	Food	Resident Days	1,316,550	66	3,806	0	12,661	37	2
3	3	Housekeeping	Resident Days	1,316,550	66	1,250	0	12,661	12	3
4	4	Laundry	Resident Days	1,316,550	66	73	0	12,661	1	4
5	5	Utilities	Resident Days	1,316,550	66	18,812	0	12,661	181	5
6	6	Maintenance	Resident Days	1,316,550	66	153,468	113,063	12,661	1,476	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	50,271	0	12,661	483	7
8	10	Nursing and Medical Records	Resident Days	1,316,550	66	291,305	286,855	12,661	2,801	8
9	10A	Therapy	Resident Days	1,316,550	66	0	0	12,661	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	64,765	0	12,661	623	10
11	17	Administrative	Resident Days	1,316,550	66	820,116	820,116	12,661	7,887	11
12	19	Professional Services	Resident Days	1,316,550	66	222,628	0	12,661	2,141	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,316,550	66	48,243	0	12,661	464	13
14	21	Clerical and General Office	Resident Days	1,316,550	66	1,867,440	1,544,801	12,661	17,959	14
15	23	Inservice Training & Education	Resident Days	1,316,550	66	21,481	0	12,661	207	15
16	24	Travel and Seminar	Resident Days	1,316,550	66	34,177	0	12,661	329	16
17	25	Other Admin. Staff Transport.	Resident Days	1,316,550	66	123,847	0	12,661	1,191	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,316,550	66	50,427	0	12,661	485	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	533,953	0	12,661	5,135	19
20	30	Depreciation	Resident Days	1,316,550	66	130,767	0	12,661	1,258	20
21	32	Interest	Resident Days	1,316,550	66	227,295	0	12,661	2,186	21
22	33	Real Estate Taxes	Resident Days	1,316,550	66	43,090	0	12,661	414	22
23	34	Rent-Facility and Grounds	Resident Days	1,316,550	66	2,648	0	12,661	25	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,316,550	66	34,690	0	12,661	334	24
25	TOTALS					\$ 4,854,723	\$ 2,874,422		\$ 46,688	25

Facility Name & ID Number Rochelle Rehab & Healthcare Center# 0048561 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Petersen Companies, LLC
 Street Address 830 W. 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	Resident Days	179,368	12	\$	12,661	\$	1
2	2	Food	Resident Days	179,368	12		12,661		2
3	3	Housekeeping	Resident Days	179,368	12	70	12,661	5	3
4	4	Laundry	Resident Days	179,368	12		12,661		4
5	5	Utilities	Resident Days	179,368	12		12,661		5
6	6	Maintenance	Resident Days	179,368	12	1,038	12,661	73	6
7	7	Mgmt. Allocation of Benefits	Resident Days	179,368	12		12,661		7
8	10	Nursing and Medical Records	Resident Days	179,368	12	189	12,661	13	8
9	10A	Therapy	Resident Days	179,368	12		12,661		9
10	15	Mgmt. Allocation of Benefits	Resident Days	179,368	12		12,661		10
11	17	Administrative	Resident Days	179,368	12		12,661		11
12	19	Professional Services	Resident Days	179,368	12	10,592	12,661	748	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	179,368	12		12,661		13
14	21	Clerical and General Office	Resident Days	179,368	12	22,877	12,661	1,615	14
15	23	Inservice Training & Education	Resident Days	179,368	12	300	12,661	21	15
16	24	Travel and Seminar	Resident Days	179,368	12		12,661		16
17	25	Other Admin. Staff Transport.	Resident Days	179,368	12	993	12,661	70	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	179,368	12	1,070	12,661	76	18
19	27	Mgmt. Allocation of Benefits	Resident Days	179,368	12		12,661		19
20	30	Depreciation	Resident Days	179,368	12	2,941	12,661	207	20
21	32	Interest	Resident Days	179,368	12	34,114	12,661	2,408	21
22	33	Real Estate Taxes	Resident Days	179,368	12		12,661		22
23	34	Rent-Facility and Grounds	Resident Days	179,368	12		12,661		23
24	35	Rent-Equipment & Vehicles	Resident Days	179,368	12		12,661		24
25	TOTALS					\$ 74,184	\$	\$ 5,236	25

Facility Name & ID Number

Rochelle Rehab & Healthcare Center

0048561

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
	A. Directly Facility Related																	
	Long-Term																	
1	Soy Capital		X	Mortgage	\$31,968.00	10/31/06	\$ 2,312,800	\$ 2,261,439	11/1/09	0.0755	\$ 162,879	1						
2	Soy Capital		X	Vehicle	\$690.00	5/7/07	28,738	25,046	5/7/11	0.0700	1,136	2						
3												3						
4							PHC allocation				2,186	4						
5							PC allocation				2,408	5						
	Working Capital																	
6												6						
7												7						
8												8						
9	TOTAL Facility Related				\$32,658.00		\$ 2,341,538	\$ 2,286,485			\$ 168,609	9						
	B. Non-Facility Related*																	
10							Amortization of Loan Costs				5,151	10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ 5,151	14						
15	TOTALS (line 9+line14)						\$ 2,341,538	\$ 2,286,485			\$ 173,760	15						

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

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

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

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2006 report.		\$	31,816	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2006	\$	24,645	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(7,171)	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	26,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. Home Office Allocation			414	
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.		\$	19,243	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002	8
	2003	9
	2004	10
	2005	11
	2006	24,645

Accrual based on prior year tax bill.

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2006	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2007 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rochelle Rehab & Healthcare Center COUNTY Ogle

FACILITY IDPH LICENSE NUMBER 0048561

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2006 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2006.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>24-24-179-007</u>	<u>Long-Term Care Facility</u>	\$ <u>24,645.42</u>	\$ <u>24,645.42</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>24,645.42</u>	\$ <u>24,645.42</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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

Facility Name & ID Number Rochelle Rehab & Healthcare Center

0048561

Report Period Beginning:

01/01/2007 Ending:

12/31/2007

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 14,800 B. General Construction Type: Exterior Brick Frame Concrete Block Number of Stories 1

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

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

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

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>52,272</u>	<u>2006</u>	<u>\$ 90,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	<u>52,272</u>		<u>\$ 90,000</u>	<u>3</u>

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	50	2006		\$ 2,182,000	\$	30	\$ 72,733	\$ 72,733	\$ 109,100	4
5										5
6										6
7	Home Office Allocation			7,059			172	172		7
8										8
Improvement Type**										
9	Remodel Shower		2007	35,270		15	1,176	1,176	1,176	9
10	Draperies		2007	1,419		10	71	71	71	10
11	Carpeting		2007	9,122		10	456	456	456	11
12	Office Room Installation		2007	2,075		15	69	69	69	12
13	Exterior Sign		2007	4,130		15	138	138	138	13
14	Painting of 10 Rooms		2007	6,175		15	206	206	206	14
15	Wallpaper In Living Room, Dining Room, TV Room		2007	3,638		15	121	121	121	15
16	Flooring for Dining Room		2007	2,681		15	90	90	90	16
17										17
18										18
19										19
20					87,280			(87,280)		20
21	Buildings Booked				1,680			(1,680)		21
22	Building Improvements Booked									22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31	2007-Home Office Allocation-Building Improvements			472			28	28		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

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)	\$ 2,254,041	\$ 88,960		\$ 75,260	\$ (13,700)	\$ 111,427	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 392,385	\$ 58,118	\$ 39,239	\$ (18,879)	10	\$ 58,858	71
72	Current Year Purchases	15,410		771	771	10	771	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			1,265	1,265			74
75	TOTALS	\$ 407,795	\$ 58,118	\$ 41,275	\$ (16,843)		\$ 59,629	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	2007 Ford Econoline Van	2007	\$ 28,738	\$ 3,832	\$ 2,874	\$ (958)		\$ 2,874	76
77										77
78										78
79										79
80	TOTALS			\$ 28,738	\$ 3,832	\$ 2,874	\$ (958)		\$ 2,874	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,780,574	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 150,910	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 119,409	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (31,501)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 173,930	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: 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>25</u>			6
7	TOTAL				\$ <u>25</u>			7

8. List separately any amortization of lease expense included on page 4, line 34. _____

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

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

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ 3,292 Description: See Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18			<u>N/A</u>	_____	18
19			_____	_____	19
20			_____	_____	20
21	TOTAL		\$ _____	\$ _____	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____/2008 \$ _____

13. _____/2009 \$ _____

14. _____/2010 \$ _____

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

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

Rochelle Rehab & Healthcare Center

0048561

Period Beginning 01/01/2007

Period End 12/31/2007

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$ 2,300
Dishwasher	658
Home Office Allocation	<u>334</u>
	<u><u>3,292</u></u>

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	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(1)&(3)	745 hrs	\$ 22,478	1,517	\$ 22,748		2,262	\$ 45,226	1
2	Licensed Speech and Language Development Therapist		hrs		93	1,392		93	1,392	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(1)&(3)	1300 hrs	39,110	2,805	42,081		4,105	81,191	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescripts				71,034		71,034	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			\$ 61,588	4,415	\$ 66,221	\$ 71,034	6,460	\$ 198,843	14

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

Facility Name & ID Number **Rochelle Rehab & Healthcare Center**

0048561

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

Ending:

12/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2007**

(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	\$ (1,164,395)	\$ (1,164,395)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>N/A</u>)	1,252,865	1,252,865	3
4	Supply Inventory (priced at <u> </u>)			4
5	Short-Term Investments			5
6	Prepaid Insurance	8,183	8,183	6
7	Other Prepaid Expenses	8,175	8,175	7
8	Accounts Receivable (owners or related parties)	3,106	3,106	8
9	Other(specify): <u> </u>			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 107,934	\$ 107,934	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	90,000	90,000	13
14	Buildings, at Historical Cost	2,182,000	2,189,059	14
15	Leasehold Improvements, at Historical Cost	63,090	64,982	15
16	Equipment, at Historical Cost	437,952	436,533	16
17	Accumulated Depreciation (book methods)	(187,750)	(173,930)	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): <u> </u>	8,848	8,848	22
23	Other(specify): <u> </u>			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,594,140	\$ 2,615,492	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,702,074	\$ 2,723,426	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 243,039	\$ 243,039	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	74,593	74,593	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,596	2,596	31
32	Accrued Real Estate Taxes(Sch.IX-B)	26,000	26,000	32
33	Accrued Interest Payable	13,691	13,691	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	17,057	17,057	36
37	<u> </u>			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 376,976	\$ 376,976	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	25,046	25,046	39
40	Mortgage Payable	2,261,439	2,261,439	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u> </u>			43
44	<u> </u>			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,286,485	\$ 2,286,485	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,663,461	\$ 2,663,461	46
47	TOTAL EQUITY(page 18, line 24)	\$ 38,613	\$ 59,965	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,702,074	\$ 2,723,426	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	30,928	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) R/E as of 1/1/07-Not Required to Prev Rpt	7,685	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 38,613	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)	\$ 38,613	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 1,493,401	1
2	Discounts and Allowances for all Levels	225,508	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,718,909	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	280,632	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 280,632	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	232	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	111,208	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	14,297	20
21	Other Medical Services	3,750	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 129,487	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Revenue</u>	18	28
28a	<u>Vending Income</u>	8	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 26	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,129,054	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	420,967	31
32	Health Care	885,394	32
33	General Administration	271,963	33
	B. Capital Expense		
34	Ownership	341,863	34
	C. Ancillary Expense		
35	Special Cost Centers	148,239	35
36	Provider Participation Fee	29,700	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,098,126	40
41	Income before Income Taxes (line 30 minus line 40)**	30,928	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 30,928	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. Facility is a division of a larger entity.

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

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

Facility Name & ID Number Rochelle Rehab & Healthcare Center

0048561

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,605	1,723	\$ 48,356	\$ 28.07	1
2	Assistant Director of Nursing	183	192	4,608	24.00	2
3	Registered Nurses	2,410	2,434	60,737	24.95	3
4	Licensed Practical Nurses	5,900	6,145	139,478	22.70	4
5	CNAs & Orderlies	23,541	23,564	288,466	12.24	5
6	CNA Trainees					6
7	Licensed Therapist	2,045	2,045	61,588	30.12	7
8	Rehab/Therapy Aides	54	54	773	14.31	8
9	Activity Director	1,709	1,744	17,278	9.91	9
10	Activity Assistants	552	552	3,979	7.21	10
11	Social Service Workers	2,080	2,080	36,958	17.77	11
12	Dietician					12
13	Food Service Supervisor	2,325	2,325	38,501	16.56	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,131	7,131	63,645	8.93	15
16	Dishwashers					16
17	Maintenance Workers	2,074	2,074	35,459	17.10	17
18	Housekeepers	8,889	8,897	90,794	10.21	18
19	Laundry	864	864	6,365	7.37	19
20	Administrator	1,634	1,760	55,495	31.53	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	565	774	4,114	5.32	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: Care Plan Coord.	1,891	1,891	51,050	27.00	32
33	Other(specify) <u>Marketing</u>	900	900	21,323	23.69	33
34	TOTAL (lines 1 - 33)	66,352	67,149	\$ 1,028,967 *	\$ 15.32	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	31 hrs.	\$ 1,611	1(3)	35
36	Medical Director	Monthly	18,000	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	550	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)		\$ 20,161		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$		50
51	Licensed Practical Nurses	1,234	51,133	10(3)	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,234	\$ 51,133		53

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>Teresa Blair</u>	<u>Administrator</u>	<u>0</u>	\$ <u>50,250</u>	<u>Workers' Compensation Insurance</u>	\$ <u>14,011</u>	<u>IDPH License Fee</u>	\$ <u>1,400</u>	
<u>Collette Smart</u>	<u>Administrator</u>	<u>0</u>	<u>5,245</u>	<u>Unemployment Compensation Insurance</u>	<u>38,456</u>	<u>Advertising: Employee Recruitment</u>	<u>5,531</u>	
				<u>FICA Taxes</u>	<u>78,083</u>	<u>Health Care Worker Background Check</u>		
				<u>Employee Health Insurance</u>	<u>(4,200)</u>	(Indicate # of checks performed)		
				<u>Employee Meals</u>		<u>Patient Background Checks</u>	<u>54</u>	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Miscellaneous Dues & Subscriptions</u>	<u>330</u>	
				<u>Smoking Cessation</u>	<u>180</u>	<u>Home Office Allocation</u>	<u>464</u>	
				<u>Employee Relations</u>	<u>475</u>	<u>Miscellaneous Licenses & Permits</u>	<u>579</u>	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ <u>55,495</u>			<u>LTC Solutions License</u>	<u>1,600</u>	
(List each licensed administrator separately.)								
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			\$ <u>127,005</u>	
Description			Amount			TOTAL (agree to Sch. V, line 20, col. 8)		
<u>Management Fees-See Page 6, Eliminated on P 3, C 7</u>			<u>\$ 41,000</u>			<u>Less: Public Relations Expense</u>	<u>(270)</u>	
						<u>Non-allowable advertising</u>	()	
						<u>Yellow page advertising</u>	()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ <u>41,000</u>					
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				
C. Professional Services				Description			Amount	
Vendor/Payee	Type		Amount		Line #		Amount	
<u>Rochelle Municipal Utilities</u>	<u>Computer Services</u>		<u>\$ 244</u>				<u>\$</u>	
<u>American Data</u>	<u>Computer Services</u>		<u>3,396</u>					
<u>Tohtz Consulting</u>	<u>Computer Services</u>		<u>2,000</u>	<u>N/A</u>				
<u>Comcast Cable</u>	<u>Computer Services</u>		<u>635</u>					
<u>E-Health Data Solutions</u>	<u>Computer Services</u>		<u>2,775</u>					
<u>LTC Solutions</u>	<u>Computer Services</u>		<u>330</u>					
<u>McGladrey & Pullen, LLP</u>	<u>Accounting Services</u>		<u>3,320</u>					
<u>CES, Inc.</u>	<u>Computer Services</u>		<u>212</u>					
TOTAL (agree to Schedule V, line 19, column 3)			\$ <u>12,912</u>	TOTAL			\$	
(If total legal fees exceed \$5,000, attach copy of invoices.)				G. Schedule of Travel and Seminar**				
				Description			Amount	
				<u>Out-of-State Travel</u>			<u>\$</u>	
				<u>In-State Travel</u>				
				<u>Seminar Expense</u>				
				<u>Home Office Allocation</u>			<u>329</u>	
				<u>Entertainment Expense</u>			()	
				TOTAL (agree to Sch. V, line 24, col. 8)			\$ <u>329</u>	

* Attach copy of IMRF notifications

**See instructions.

Rochelle Rehab & Healthcare Center

0048561

Period Beginning 01/01/2007

Period End 12/31/2007

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		12,912

Home Office Allocation

Pearl & Associates	Legal	14
Addy Bush & Assoc	Legal	7
Registered Agent Solutions	Legal	1
Heyl, Royster, Voelker & Allen	Legal	31
Duane Morris	Legal	48
Ginoli & Co.	Accountants	788
RSM McGladrey	Accountants	498
McGladrey & Pullen	Accountants	129
Emdeon Business Services	Computer Services	34
Advanced Answers on Demand	Computer Services	916
Access 2 Go	Computer Services	68
Ivans	Computer Services	60
Kemper Technology	Computer Services	142
Adminastar Federal	Computer Services	18
Logmein	Computer Services	11
E-Health Data Solutions	Computer Services	89
Illinois Secretary of State	Computer Services	35

Total (agree to Schedule V, line 19, column 8)	<u>15,801</u>
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Facility Name & ID Number Rochelle Rehab & Healthcare Center# 0048561Report Period Beginning: 01/01/2007Ending: 12/31/2007**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? 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? 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 207 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. \$ 29,700
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 232
- (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? 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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees