



Facility Name & ID Number Shelbyville Rehabilitation & Health Care Center

# 0047563 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	12	Skilled (SNF)	12	4,380	1
2		Skilled Pediatric (SNF/PED)			2
3	68	Intermediate (ICF)	68	24,820	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	80	TOTALS	80	29,200	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			1,618	1,618	8
9	SNF/PED					9
10	ICF	9,445	1,795		11,240	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,445	1,795	1,618	12,858	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 44.03%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

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

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES

NO

Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES

NO

I. On what date did you start providing long term care at this location?

Date started 10/1/05

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

YES

Date 10/1/05

NO

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

YES

NO

If YES, enter number of beds certified 12 and days of care provided 1,618

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 Shelbyville Rehabilitation & Health Care Cen # 0047563 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
	<b>A. General Services</b>										
1	Dietary	93,304	8,196		101,500		101,500	2,589	104,089		1
2	Food Purchase		74,352		74,352		74,352	(3,891)	70,461		2
3	Housekeeping	37,782	4,944		42,726		42,726	12	42,738		3
4	Laundry	13,633	4,566		18,199		18,199	1	18,200		4
5	Heat and Other Utilities			51,113	51,113		51,113	184	51,297		5
6	Maintenance	24,669	211	8,932	33,812		33,812	1,509	35,321		6
7	Other (specify):* Home Off. Ben. All.							1,753	1,753		7
8	<b>TOTAL General Services</b>	169,388	92,269	60,045	321,702		321,702	2,157	323,859		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	437,354	17,929	1,135	456,418		456,418	4,623	461,041		10
10a	Therapy			107,775	107,775		107,775		107,775		10a
11	Activities	14,559	893	832	16,284		16,284	(490)	15,794		11
12	Social Services	26,516			26,516		26,516		26,516		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.							2,112	2,112		15
16	<b>TOTAL Health Care and Programs</b>	478,429	18,822	115,742	612,993		612,993	6,245	619,238		16
	<b>C. General Administration</b>										
17	Administrative	51,683		38,000	89,683		89,683	(23,809)	65,874		17
18	Directors Fees										18
19	Professional Services			8,105	8,105		8,105	3,959	12,064		19
20	Dues, Fees, Subscriptions & Promotions			9,042	9,042		9,042	511	9,553		20
21	Clerical & General Office Expenses	4,712	3,361	12,236	20,309		20,309	19,732	40,041		21
22	Employee Benefits & Payroll Taxes			107,470	107,470		107,470		107,470		22
23	Inservice Training & Education							210	210		23
24	Travel and Seminar							334	334		24
25	Other Admin. Staff Transportation			1,329	1,329		1,329	2,176	3,505		25
26	Insurance-Prop.Liab.Malpractice			9,956	9,956		9,956	492	10,448		26
27	Other (specify):* Home Off. Ben. All.							10,370	10,370		27
28	<b>TOTAL General Administration</b>	56,395	3,361	186,138	245,894		245,894	13,975	259,869		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	704,212	114,452	361,925	1,180,589		1,180,589	22,377	1,202,966		29

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

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

Facility Name &amp; ID Number

Shelbyville Rehabilitation &amp; Health Care Center

#0047563

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	
	<b>D. Ownership</b>											
30	Depreciation			66,102	66,102		66,102	580	66,682			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			58,745	58,745		58,745	28,737	87,482			32
33	Real Estate Taxes			14,433	14,433		14,433	421	14,854			33
34	Rent-Facility & Grounds							26	26			34
35	Rent-Equipment & Vehicles			13,453	13,453		13,453	339	13,792			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			152,733	152,733		152,733	30,103	182,836			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		42,760		42,760		42,760		42,760			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			43,800	43,800		43,800		43,800			42
43	Other (specify):* Non-allowable Cost	9,464	340	51,968	61,772		61,772	(61,772)				43
44	<b>TOTAL Special Cost Centers</b>	9,464	43,100	95,768	148,332		148,332	(61,772)	86,560			44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	713,676	157,552	610,426	1,481,654		1,481,654	(9,292)	1,472,362			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				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(1,427)	30		9
10	Interest and Other Investment Income	(740)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(640)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(39,695)	43		24
25	Fund Raising, Advertising and Promotional	(17,761)	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	(8,337)	Various		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (68,600)		\$	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)	59,308	Various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 59,308		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (9,292)		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

Shelbyville Rehabilitation & Health Care Center

ID# 0047563

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (2,923)	43	1
2	X-Rays-Part A	(553)	43	2
3	Day Care Revenue offset	(490)	11	3
4	Offset Miscellaneous Food Revenue	(3,928)	2	4
5	Offset Miscellaneous Office Supplies Revenue	(243)	21	5
6	Vending Machine	(200)	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
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26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(8,337)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Shelbyville Rehabilitation & Health Care Center# 0047563

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	1,076	0	1,513	0	0	0	0	0	0	0	2,589	1
2	Food Purchase	(3,928)	37	0	0	0	0	0	0	0	0	0	(3,891)	2
3	Housekeeping	0	12	0	0	0	0	0	0	0	0	0	12	3
4	Laundry	0	1	0	0	0	0	0	0	0	0	0	1	4
5	Heat and Other Utilities	0	184	0	0	0	0	0	0	0	0	0	184	5
6	Maintenance	0	1,499	0	10	0	0	0	0	0	0	0	1,509	6
7	Other (specify):*	0	491	0	1,262	0	0	0	0	0	0	0	1,753	7
8	<b>TOTAL General Services</b>	<b>(3,928)</b>	<b>3,300</b>	<b>0</b>	<b>2,785</b>	<b>0</b>	<b>2,157</b>	<b>8</b>						
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	2,845	0	1,778	0	0	0	0	0	0	0	4,623	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(490)	0	0	0	0	0	0	0	0	0	0	(490)	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	633	0	1,479	0	0	0	0	0	0	0	2,112	15
16	<b>TOTAL Health Care and Programs</b>	<b>(490)</b>	<b>3,478</b>	<b>0</b>	<b>3,257</b>	<b>0</b>	<b>6,245</b>	<b>16</b>						
	<b>C. General Administration</b>													
17	Administrative	0	(29,990)	0	6,181	0	0	0	0	0	0	0	(23,809)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	2,174	0	1,785	0	0	0	0	0	0	0	3,959	19
20	Fees, Subscriptions & Promotions	0	0	471	40	0	0	0	0	0	0	0	511	20
21	Clerical & General Office Expenses	(243)	0	18,238	1,737	0	0	0	0	0	0	0	19,732	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	210	0	0	0	0	0	0	0	0	210	23
24	Travel and Seminar	0	0	334	0	0	0	0	0	0	0	0	334	24
25	Other Admin. Staff Transportation	0	0	1,210	966	0	0	0	0	0	0	0	2,176	25
26	Insurance-Prop.Liab.Malpractice	0	0	492	0	0	0	0	0	0	0	0	492	26
27	Other (specify):*	0	0	5,215	5,155	0	0	0	0	0	0	0	10,370	27
28	<b>TOTAL General Administration</b>	<b>(243)</b>	<b>(27,816)</b>	<b>26,170</b>	<b>15,864</b>	<b>0</b>	<b>13,975</b>	<b>28</b>						
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(4,661)</b>	<b>(21,038)</b>	<b>26,170</b>	<b>21,906</b>	<b>0</b>	<b>22,377</b>	<b>29</b>						

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Shelbyville Rehabilitation & Health Care Center# 0047563

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(1,427)	0	1,277	730	0	0	0	0	0	0	0	580	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(740)	0	2,220	27,257	0	0	0	0	0	0	0	28,737	32
33	Real Estate Taxes	0	0	421	0	0	0	0	0	0	0	0	421	33
34	Rent-Facility & Grounds	0	0	26	0	0	0	0	0	0	0	0	26	34
35	Rent-Equipment & Vehicles	0	0	339	0	0	0	0	0	0	0	0	339	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(2,167)</b>	<b>0</b>	<b>4,283</b>	<b>27,987</b>	<b>0</b>	<b>30,103</b>	<b>37</b>						
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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):*	(61,772)	0	0	0	0	0	0	0	0	0	0	(61,772)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(61,772)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(61,772)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(68,600)</b>	<b>(21,038)</b>	<b>30,453</b>	<b>49,893</b>	<b>0</b>	<b>(9,292)</b>	<b>45</b>						

**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%	\$ 1,076	\$ 1,076	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%	184	184	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	1,499	1,499	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	491	491	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	2,845	2,845	8
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	633	633	10
11	V	17 Administrative	38,000	Petersen Health Care, Inc.	100.00%	8,010	(29,990)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	2,174	2,174	12
13	V							13
14	Total		\$ 38,000			\$ 16,962	\$ * (21,038)	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 Prmotions	\$	Petersen Health Care, Inc.	100.00%	\$ 471	\$	471	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	18,238		18,238	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	210		210	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	334		334	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	1,210		1,210	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	492		492	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	5,215		5,215	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	1,277		1,277	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	2,220		2,220	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	421		421	24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	26		26	25
26	V	35 Rent-Equipment and Vehicles		Petersen Health Care, Inc.	100.00%	339		339	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	<b>Total</b>		\$			\$ 30,453	\$ *	30,453	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1 Dietary	\$	Petersen Health Operations, LLC	100.00%	\$ 1,513	\$	1,513	15
16	V	2 Food		Petersen Health Operations, LLC	100.00%	0		0	16
17	V	3 Housekeeping		Petersen Health Operations, LLC	100.00%	0		0	17
18	V	4 Laundry		Petersen Health Operations, LLC	100.00%	0		0	18
19	V	5 Utilities		Petersen Health Operations, LLC	100.00%	0		0	19
20	V	6 Maintenance		Petersen Health Operations, LLC	100.00%	10		10	20
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	1,262		1,262	21
22	V	10 Nursing and Medical Records		Petersen Health Operations, LLC	100.00%	1,778		1,778	22
23	V	10A Therapy		Petersen Health Operations, LLC	100.00%	0		0	23
24	V	15 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	1,479		1,479	24
25	V	17 Administrative		Petersen Health Operations, LLC	100.00%	6,181		6,181	25
26	V	19 Professional Services		Petersen Health Operations, LLC	100.00%	1,785		1,785	26
27	V	20 Dues, Fees, Subs and Prmotions		Petersen Health Operations, LLC	100.00%	40		40	27
28	V	21 Clerical and General Office		Petersen Health Operations, LLC	100.00%	1,737		1,737	28
29	V	23 Inservice Training and Education		Petersen Health Operations, LLC	100.00%	0		0	29
30	V	24 Travel and Seminar		Petersen Health Operations, LLC	100.00%	0		0	30
31	V	25 Other Admin. Staff Transportation		Petersen Health Operations, LLC	100.00%	966		966	31
32	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Operations, LLC	100.00%	0		0	32
33	V	27 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	5,155		5,155	33
34	V	30 Depreciation		Petersen Health Operations, LLC	100.00%	730		730	34
35	V	32 Interest		Petersen Health Operations, LLC	100.00%	27,257		27,257	35
36	V	33 Real Estate Taxes		Petersen Health Operations, LLC	100.00%	0		0	36
37	V	34 Rent-Facility and Grounds		Petersen Health Operations, LLC	100.00%	0		0	37
38	V	35 Rent-Equipment and Vehicles		Petersen Health Operations, LLC	100.00%	0		0	38
39	Total		\$			\$ 49,893	\$ *	49,893	39

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

Facility Name & ID Number Shelbyville Rehabilitation & Health Care Ce # 0047563 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	0.53	0.96	Salary	\$ 8,010	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	\$ 8,010		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 Shelbyville Rehabilitation & Health Care Center # 0047563 Report Period Beginning: 01/01/2007 Ending: 2/31/2007

## VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Petersen Health 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	12,858	\$ 1,076	1
2	2	Food	Resident Days	1,316,550	66	3,806	0	12,858	37	2
3	3	Housekeeping	Resident Days	1,316,550	66	1,250	0	12,858	12	3
4	4	Laundry	Resident Days	1,316,550	66	73	0	12,858	1	4
5	5	Utilities	Resident Days	1,316,550	66	18,812	0	12,858	184	5
6	6	Maintenance	Resident Days	1,316,550	66	153,468	113,063	12,858	1,499	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	50,271	0	12,858	491	7
8	10	Nursing and Medical Records	Resident Days	1,316,550	66	291,305	286,855	12,858	2,845	8
9	10A	Therapy	Resident Days	1,316,550	66	0	0	12,858	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	64,765	0	12,858	633	10
11	17	Administrative	Resident Days	1,316,550	66	820,116	820,116	12,858	8,010	11
12	19	Professional Services	Resident Days	1,316,550	66	222,628	0	12,858	2,174	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,316,550	66	48,243	0	12,858	471	13
14	21	Clerical and General Office	Resident Days	1,316,550	66	1,867,440	1,544,801	12,858	18,238	14
15	23	Inservice Training & Education	Resident Days	1,316,550	66	21,481	0	12,858	210	15
16	24	Travel and Seminar	Resident Days	1,316,550	66	34,177	0	12,858	334	16
17	25	Other Admin. Staff Transport.	Resident Days	1,316,550	66	123,847	0	12,858	1,210	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,316,550	66	50,427	0	12,858	492	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	533,953	0	12,858	5,215	19
20	30	Depreciation	Resident Days	1,316,550	66	130,767	0	12,858	1,277	20
21	32	Interest	Resident Days	1,316,550	66	227,295	0	12,858	2,220	21
22	33	Real Estate Taxes	Resident Days	1,316,550	66	43,090	0	12,858	421	22
23	34	Rent-Facility and Grounds	Resident Days	1,316,550	66	2,648	0	12,858	26	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,316,550	66	34,690	0	12,858	339	24
25	TOTALS					\$ 4,854,723	\$ 2,874,422		\$ 47,415	25

Facility Name & ID Number Shelbyville Rehabilitation & Health Care Center# 0047563

Report Period Beginning:

01/01/2007Ending: 2/31/2007

## VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization

Petersen Health Operations, LLC

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

( 309) 691-8113

Fax Number

( 309) 691-8622

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	440,525	23	\$ 51,832	\$ 51,832	12,858	\$ 1,513	1
2	2	Food	Resident Days	440,525	23			12,858		2
3	3	Housekeeping	Resident Days	440,525	23			12,858		3
4	4	Laundry	Resident Days	440,525	23			12,858		4
5	5	Utilities	Resident Days	440,525	23			12,858		5
6	6	Maintenance	Resident Days	440,525	23	358		12,858	10	6
7	7	Mgmt. Allocation of Benefits	Resident Days	440,525	23	43,237		12,858	1,262	7
8	10	Nursing and Medical Records	Resident Days	440,525	23	60,910	60,761	12,858	1,778	8
9	10A	Therapy	Resident Days	440,525	23			12,858		9
10	15	Mgmt. Allocation of Benefits	Resident Days	440,525	23	50,681		12,858	1,479	10
11	17	Administrative	Resident Days	440,525	23	211,751	211,751	12,858	6,181	11
12	19	Professional Services	Resident Days	440,525	23	61,162		12,858	1,785	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	440,525	23	1,373		12,858	40	13
14	21	Clerical and General Office	Resident Days	440,525	23	59,529		12,858	1,737	14
15	23	Inservice Training & Education	Resident Days	440,525	23			12,858		15
16	24	Travel and Seminar	Resident Days	440,525	23	10		12,858		16
17	25	Other Admin. Staff Transport.	Resident Days	440,525	23	33,098		12,858	966	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	440,525	23			12,858		18
19	27	Mgmt. Allocation of Benefits	Resident Days	440,525	23	176,624		12,858	5,155	19
20	30	Depreciation	Resident Days	440,525	23	24,996		12,858	730	20
21	32	Interest	Resident Days	440,525	23	933,842		12,858	27,257	21
22	33	Real Estate Taxes	Resident Days	440,525	23			12,858		22
23	34	Rent-Facility and Grounds	Resident Days	440,525	23			12,858		23
24	35	Rent-Equipment & Vehicles	Resident Days	440,525	23			12,858		24
25	TOTALS					\$ 1,709,403	\$ 324,344		\$ 49,893	25





**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 Shelbyville Rehabilitation & Health Care Center COUNTY Shelby

FACILITY IDPH LICENSE NUMBER 0047563

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

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

**A. Summary of Real Estate Tax 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>1812-13-01-103-005</u>	<u>Long-Term Care Facility</u>	\$ <u>26,896.30</u>	\$ <u>26,896.30</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>26,896.30</u>	\$ <u>26,896.30</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 Shelbyville Rehabilitation & Health Care Center

# 0047563

Report Period Beginning:

01/01/2007 Ending:

12/31/2007

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 16,099 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

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

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

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

N/A

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

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

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

**XI. OWNERSHIP COSTS:**

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

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	80	2005	1971	\$ 855,750	\$	25	\$ 34,230	\$ 34,230	\$ 85,575	4
5										5
6										6
7	Home Office Allocation			7,168			175	175		7
8										8
<b>Improvement Type**</b>										
9										9
10	Original Land Improvements	2005		15,000		15	1,000	1,000	2,500	10
11	Sidewalks	2006		6,365		15	424	424	636	11
12	Water Heater	2006		6,609		10	330	330	330	12
13	Building Repair (Wind Damage)	2007		4,308		15	144	144	144	13
14										14
15										15
16										16
17										17
18	Land Improvement Booked				1,424			(1,424)		18
19	Building Booked				34,256			(34,256)		19
20	Building Improvements Booked				72			(72)		20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30	2007-Home Office Allocation-Land Improvements			480			28	28		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

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)	\$ 895,680	\$ 35,752		\$ 36,331	\$ 579	\$ 89,185	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	\$ 181,720	\$ 28,401	\$ 27,759	\$ (642)	3-7	\$ 66,902	71
72	Current Year Purchases	15,752	1,949	788	(1,161)	10	788	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			1,804	1,804			74
75	TOTALS	\$ 197,472	\$ 30,350	\$ 30,351	\$ 1		\$ 67,690	75

D. Vehicle Depreciation (See instructions.)\*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,140,402	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 66,102	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 66,682	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 580	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 156,875	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>26</u>			6
7	TOTAL				\$ <u>26</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: \$ 13,792 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.

Shelbyville Rehabilitation & Health Care Center  
0047563

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**

Copier	\$ 2,729
Dishwasher	561
Medical Equipment	10,163
Home Office Allocation	339
	<u>13,792</u>

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	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	L. 10A, C. 3	hrs	\$	2,888	\$ 43,327	\$	2,888	\$ 43,327	1
2	Licensed Speech and Language Development Therapist	L. 10A ,C. 3	hrs		438	6,565		438	6,565	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L. 10A, C. 3	hrs		3,859	57,883		3,859	57,883	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L. 39, C. 2	# of prescrpts				42,760		42,760	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	<b>TOTAL</b>			\$	7,185	\$ 107,775	\$ 42,760	7,185	\$ 150,535	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 Shelbyville Rehabilitation & Health Care Center

# 0047563

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*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ (659,243)	\$ (659,243)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>N/A</u> )	295,486	295,486	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	11,459	11,459	6
7	Other Prepaid Expenses	14,315	14,315	7
8	Accounts Receivable (owners or related parties)	(30,063)	(30,063)	8
9	Other(specify): _____			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ (368,046)	\$ (368,046)	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		47,250	13
14	Buildings, at Historical Cost	924,365	863,398	14
15	Leasehold Improvements, at Historical Cost	4,308	32,282	15
16	Equipment, at Historical Cost	204,081	197,472	16
17	Accumulated Depreciation (book methods)	(141,958)	(156,875)	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>Due from prior owner</u>	806	806	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 991,602	\$ 984,333	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 623,556	\$ 616,287	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 167,725	\$ 167,725	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	15,244	15,244	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,502	4,502	31
32	Accrued Real Estate Taxes(Sch.IX-B)	28,000	28,000	32
33	Accrued Interest Payable	2,483	2,483	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Accrued Expenses</u>	11,945	11,945	36
37	_____			37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 229,899	\$ 229,899	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable	396,429	396,429	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	_____			43
44	_____			44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 396,429	\$ 396,429	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 626,328	\$ 626,328	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (2,772)	\$ (10,041)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 623,556	\$ 616,287	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(45,840)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Post Cost Report Audit Adjustments</b>	<b>(8,892)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(54,732)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>51,960</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>51,960</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(2,772)</b>	<b>24</b> *

\* This must agree with page 17, line 47.

Shelbyville Rehabilitation & Health Care Center  
0047563  
Period Beginning 01/01/2007  
Period End 12/31/2007

**Schedule 18A**

**XVI. Statement of Changes in Equity**

**Beginning Equity Restatements:**

**Post Cost Report Audit Adjustments**

After filing the previous year's State of Illinois Financial and Statistical Report for Long-Term Care Facilities, an adjustment was made to the facility's financial records to properly state bad debt expense. Therefore, an adjustment to the current year's beginning equity is necessary to reconcile the previous year's cost report equity to the current year's equity per books. After this adjustment, cost report equity agrees to book equity on Schedule XVI.

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

1

Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 1,205,446	1
2	Discounts and Allowances for all Levels	102,148	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 1,307,594	3
<b>B. Ancillary Revenue</b>			
4	Day Care	490	4
5	Other Care for Outpatients		5
6	Therapy	140,591	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 141,081	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	152	13
14	Non-Patient Meals	3,928	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	68,087	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	6,259	20
21	Other Medical Services	5,530	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 83,956	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	740	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 740	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Miscellaneous Revenue</b>	243	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 243	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 1,533,614	30

2

Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	321,702	31
32	Health Care	612,993	32
33	General Administration	245,894	33
<b>B. Capital Expense</b>			
34	Ownership	152,733	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	104,532	35
36	Provider Participation Fee	43,800	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 1,481,654	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	51,960	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 51,960	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 Shelbyville Rehabilitation & Health Care Center

# 0047563

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	1,082	1,229	\$ 25,974	\$ 21.13	1
2	Assistant Director of Nursing	501	519	9,540	18.38	2
3	Registered Nurses	3,558	3,639	69,844	19.19	3
4	Licensed Practical Nurses	7,177	7,473	122,147	16.35	4
5	CNAs & Orderlies	20,296	20,898	184,607	8.83	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	952	952	8,583	9.02	9
10	Activity Assistants	586	586	5,976	10.20	10
11	Social Service Workers	2,080	2,080	26,516	12.75	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	26,326	12.66	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,352	8,687	66,978	7.71	15
16	Dishwashers					16
17	Maintenance Workers	2,080	2,080	24,669	11.86	17
18	Housekeepers	5,096	5,134	37,782	7.36	18
19	Laundry	1,822	1,902	13,633	7.17	19
20	Administrator	2,080	2,080	51,683	24.85	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	568	580	4,712	8.12	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care: Care Plan Coordin	1,389	1,488	25,242	16.96	32
33	Other(specify) <u>Marketing</u>	676	676	9,464	14.00	33
34	TOTAL (lines 1 - 33)	60,375	62,083	\$ 713,676 *	\$ 11.50	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$		35
36	Medical Director	Monthly 6,000	L. 9, C. 3	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 1,049	L.10, C. 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)	\$ 7,049		49

**C. CONTRACT NURSES**

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

**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		
Rhonda Baker	Administrator	0	\$ 51,683	Workers' Compensation Insurance	\$ 11,062	IDPH License Fee	\$ 995		
				Unemployment Compensation Insurance	32,749	Advertising: Employee Recruitment	1,369		
				FICA Taxes	52,787	Health Care Worker Background Check	2,940		
				Employee Health Insurance	7,373	(Indicate # of checks performed <u>294</u> )			
				Employee Meals		LTC Solutions license	1,600		
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Dues & Licenses	95		
						IHCA	2,043		
						Home Office Allocation	511		
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 51,683	Employee Retirement	285				
(List each licensed administrator separately.)				Employee Relations	3,214				
<b>B. Administrative - Other</b>									
Description			Amount						
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 38,000						
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 38,000	TOTAL (agree to Schedule V, line 22, col.8)			\$ 107,470	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 9,553
(Attach a copy of any management service agreement)									
<b>C. Professional Services</b>				<b>E. Schedule of Non-Cash Compensation Paid to Owners or Employees</b>			<b>G. Schedule of Travel and Seminar**</b>		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
McGladrey & Pullen, LLP	Accounting		\$ 6,080				Out-of-State Travel	\$	
E-Health Data Solutions	Computer Services		2,025	N/A					
							In-State Travel		
							Seminar Expense		
							Home Office Allocation	334	
							Entertainment Expense	( )	
							(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 19, column 3)			\$ 8,105	TOTAL			\$	TOTAL	\$ 334
(If total legal fees exceed \$5,000, attach copy of invoices.)									

\* Attach copy of IMRF notifications

\*\*See instructions.

Shelbyville Rehabilitation & Health Care Center  
 0047563  
 Period Beginning 01/01/2007  
 Period End 12/31/2007

**Schedule 21A**

**XIX. SUPPORT SCHEDULE  
 C. Professional Services**

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		8,105

Non-allowable legal expense

**Home Office Allocation**

**Petersen Health Care, Inc**

Pearl & Associates	Legal	14
Addy Bush & Assoc	Legal	7
Registered Agent Solutions	Legal	1
Heyl, Royster, Voelker & Allen	Legal	31
Duane Morris	Legal	49
Ginoli & Co.	Accountants	497
RSM McGladrey	Accountants	86
McGladrey & Pullen	Accountants	131
Emdeon Business Services	Computer Services	34
Advanced Answers on Demand	Computer Services	922
Access 2 Go	Computer Services	70
Ivans	Computer Services	61
Kemper Technology	Computer Services	145
Adminastar Federal	Computer Services	18
Logmein	Computer Services	11
E-Health Data Solutions	Computer Services	90
Miscellaneous Vendors	Miscellaneous	7

**Petersen Health Operations, LLC**

Ginoli & Co.	Accountants	1,104
Julie Breedlove	Computer Services	11
Ivans	Computer Services	248
Miscellaneous Vendors	Computer Services	4
Amerisearch	Employment fees	418

Non-allowable Legal

Total (agree to Schedule V, line 19, column 8)	<u>12,064</u>
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Facility Name & ID Number Shelbyville Rehabilitation & Health Care Center# 0047563Report 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? Yes  
If YES, give association name and amount. IHCA \$2043
- (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. \$ 4,753 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 43,800  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 3,928
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? N/A  
d. Have vehicle usage logs been maintained? Adequate records have been maintained.  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
g. Does the facility transport residents to and from day training? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Ginoli & Co. The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit currently in progress
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$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