

Facility Name & ID Number Sheldon Health Care Center

0046573 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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	31	Intermediate (ICF)	31	11,315	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	31	TOTALS	31	11,315	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	
8	SNF				8
9	SNF/PED				9
10	ICF	8,130	897		9,027
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	8,130	897		9,027

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.78%

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)

10 Apartment Buildings

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

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

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

I. On what date did you start providing long term care at this location?
 Date started 1/1/04

J. Was the facility purchased or leased after January 1, 1978?
 YES Date 1/1/04 NO

K. Was the facility certified for Medicare during the reporting year?
 YES NO If YES, enter number of beds certified 0 and days of care provided 0

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number Sheldon Health Care Center # 0046573 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	78,431	11,576	357	90,364		90,364	755	91,119		1
2	Food Purchase		60,862		60,862		60,862	(2,182)	58,680		2
3	Housekeeping	46,558	8,830		55,388		55,388	9	55,397		3
4	Laundry	14,047	4,837		18,884		18,884	1	18,885		4
5	Heat and Other Utilities			40,430	40,430		40,430	129	40,559		5
6	Maintenance	19,137	2,443	17,801	39,381		39,381	1,052	40,433		6
7	Other (specify):* Home Off. Ben. All.							345	345		7
8	TOTAL General Services	158,173	88,548	58,588	305,309		305,309	109	305,418		8
	B. Health Care and Programs										
9	Medical Director			3,600	3,600		3,600		3,600		9
10	Nursing and Medical Records	348,468	14,330	500	363,298		363,298	1,997	365,295		10
10a	Therapy										10a
11	Activities	28,659	525	618	29,802		29,802		29,802		11
12	Social Services										12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.							444	444		15
16	TOTAL Health Care and Programs	377,127	14,855	4,718	396,700		396,700	2,441	399,141		16
	C. General Administration										
17	Administrative	40,967		35,000	75,967		75,967	(29,377)	46,590		17
18	Directors Fees										18
19	Professional Services			7,414	7,414		7,414	2,345	9,759		19
20	Dues, Fees, Subscriptions & Promotions			6,455	6,455		6,455	254	6,709		20
21	Clerical & General Office Expenses		5,149	4,228	9,377		9,377	13,989	23,366		21
22	Employee Benefits & Payroll Taxes			148,816	148,816		148,816	4,954	153,770		22
23	Inservice Training & Education							178	178		23
24	Travel and Seminar							234	234		24
25	Other Admin. Staff Transportation			3,549	3,549		3,549	849	4,398		25
26	Insurance-Prop.Liab.Malpractice			7,216	7,216		7,216	649	7,865		26
27	Other (specify):* Home Off. Ben. All.							3,661	3,661		27
28	TOTAL General Administration	40,967	5,149	212,678	258,794		258,794	(2,264)	256,530		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	576,267	108,552	275,984	960,803		960,803	286	961,089		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 Sheldon Health Care Center

#0046573

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			49,249	49,249		49,249	(1,135)	48,114			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			25,783	25,783		25,783	4,646	30,429			32
33	Real Estate Taxes			7,511	7,511		7,511	295	7,806			33
34	Rent-Facility & Grounds							18	18			34
35	Rent-Equipment & Vehicles			2,653	2,653		2,653	238	2,891			35
36	Other (specify):*											36
37	TOTAL Ownership			85,196	85,196		85,196	4,062	89,258			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		138		138		138		138			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			16,975	16,975		16,975		16,975			42
43	Other (specify):* Non-allowable Cost		372	15,008	15,380		15,380	(15,380)				43
44	TOTAL Special Cost Centers		510	31,983	32,493		32,493	(15,380)	17,113			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	576,267	109,062	393,163	1,078,492		1,078,492	(11,032)	1,067,460			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	(2,208)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,515)	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	(2,032)	30		9
10	Interest and Other Investment Income	(563)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(346)	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	(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	(2,121)	43		24
25	Fund Raising, Advertising and Promotional	(2,283)	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	(5,214)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (20,382)		\$	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)	9,350	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 9,350		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (11,032)		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

Sheldon Health Care Center

ID# 0046573

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Resident Flowers	\$ (347)	43	1
2	Disallowed Special Events	(4,668)	2	2
3	Offset Miscellaneous Office Supplies Revenue	(110)	21	3
4	Offset Chamber of Commerce Dues	(89)	20	4
5				5
6				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	(5,214)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sheldon Health Care Center# 0046573

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 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
1	A. General Services													
1	Dietary	0	755	0	0	0	0	0	0	0	0	0	755	1
2	Food Purchase	(6,876)	26	0	0	0	0	0	0	0	0	0	(6,850)	2
3	Housekeeping	0	9	0	0	0	0	0	0	0	0	0	9	3
4	Laundry	0	1	0	0	0	0	0	0	0	0	0	1	4
5	Heat and Other Utilities	0	129	0	0	0	0	0	0	0	0	0	129	5
6	Maintenance	0	1,052	0	0	0	0	0	0	0	0	0	1,052	6
7	Other (specify):*	0	345	0	0	0	0	0	0	0	0	0	345	7
8	TOTAL General Services	(6,876)	2,317	0	0	0	0	0	0	0	0	0	(4,559)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	1,997	0	0	0	0	0	0	0	0	0	1,997	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	444	0	0	0	0	0	0	0	0	0	444	15
16	TOTAL Health Care and Programs	0	2,441	0	0	0	0	0	0	0	0	0	2,441	16
	C. General Administration													
17	Administrative	0	(29,377)	0	0	0	0	0	0	0	0	0	(29,377)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	1,526	0	819	0	0	0	0	0	0	0	2,345	19
20	Fees, Subscriptions & Promotions	(89)	0	331	12	0	0	0	0	0	0	0	254	20
21	Clerical & General Office Expenses	(110)	0	12,804	1,295	0	0	0	0	0	0	0	13,989	21
22	Employee Benefits & Payroll Taxes	0	0	0	4,954	0	0	0	0	0	0	0	4,954	22
23	Inservice Training & Education	0	0	147	31	0	0	0	0	0	0	0	178	23
24	Travel and Seminar	0	0	234	0	0	0	0	0	0	0	0	234	24
25	Other Admin. Staff Transportation	0	0	849	0	0	0	0	0	0	0	0	849	25
26	Insurance-Prop.Liab.Malpractice	0	0	346	303	0	0	0	0	0	0	0	649	26
27	Other (specify):*	0	0	3,661	0	0	0	0	0	0	0	0	3,661	27
28	TOTAL General Administration	(199)	(27,851)	18,372	7,414	0	(2,264)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(7,075)	(23,093)	18,372	7,414	0	(4,382)	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sheldon Health Care Center# 0046573

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	(2,032)	0	897	0	0	0	0	0	0	0	0	(1,135)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(563)	0	1,558	3,651	0	0	0	0	0	0	0	4,646	32
33	Real Estate Taxes	0	0	295	0	0	0	0	0	0	0	0	295	33
34	Rent-Facility & Grounds	0	0	18	0	0	0	0	0	0	0	0	18	34
35	Rent-Equipment & Vehicles	0	0	238	0	0	0	0	0	0	0	0	238	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(2,595)	0	3,006	3,651	0	4,062	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):*	(10,712)	0	0	0	0	0	0	0	0	0	0	(10,712)	43
44	TOTAL Special Cost Centers	(10,712)	0	0	0	0	0	0	0	0	0	0	(10,712)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(20,382)	(23,093)	21,378	11,065	0	(11,032)	45						

Facility Name & ID Number

Sheldon Health Care Center

0046573

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	70	See Attached Schedule 6E		See Attached Sch 6E		
Jifi Jacob	10					
Cindy S. White	10					
Jacque Whitley	10					

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%	\$ 755	\$ 755	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	26	26	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	9	9	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	1	1	4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	129	129	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	1,052	1,052	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	345	345	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	1,997	1,997	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%	444	444	10
11	V	17 Administrative	35,000	Petersen Health Care, Inc.	100.00%	5,623	(29,377)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	1,526	1,526	12
13	V							13
14	Total		\$ 35,000			\$ 11,907	\$ * (23,093)	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 <u>Dues, Fees, Subs and Promotions</u>	\$	<u>Petersen Health Care, Inc.</u>	100.00%	\$ 331	\$	331	15
16	V	21 <u>Clerical and General Office</u>		<u>Petersen Health Care, Inc.</u>	100.00%	12,804		12,804	16
17	V	23 <u>Inservice Training and Education</u>		<u>Petersen Health Care, Inc.</u>	100.00%	147		147	17
18	V	24 <u>Travel and Seminar</u>		<u>Petersen Health Care, Inc.</u>	100.00%	234		234	18
19	V	25 <u>Other Admin. Staff Transportation</u>		<u>Petersen Health Care, Inc.</u>	100.00%	849		849	19
20	V	26 <u>Insurance-Prop./Liab/Malpractice</u>		<u>Petersen Health Care, Inc.</u>	100.00%	346		346	20
21	V	27 <u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Care, Inc.</u>	100.00%	3,661		3,661	21
22	V	30 <u>Depreciation</u>		<u>Petersen Health Care, Inc.</u>	100.00%	897		897	22
23	V	32 <u>Interest</u>		<u>Petersen Health Care, Inc.</u>	100.00%	1,558		1,558	23
24	V	33 <u>Real Estate Taxes</u>		<u>Petersen Health Care, Inc.</u>	100.00%	295		295	24
25	V	34 <u>Rent-Facility and Grounds</u>		<u>Petersen Health Care, Inc.</u>	100.00%	18		18	25
26	V	35 <u>Rent-Equipment and Vehicles</u>		<u>Petersen Health Care, Inc.</u>	100.00%	238		238	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 21,378	\$ *	21,378	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 Enterprises, LLC	100.00%	\$ 0	\$ 0
16	V	2 Food		Petersen Health Enterprises, LLC	100.00%	0	0
17	V	3 Housekeeping		Petersen Health Enterprises, LLC	100.00%	0	0
18	V	4 Laundry		Petersen Health Enterprises, LLC	100.00%	0	0
19	V	5 Utilities		Petersen Health Enterprises, LLC	100.00%	0	0
20	V	6 Maintenance		Petersen Health Enterprises, LLC	100.00%	0	0
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Enterprises, LLC	100.00%	0	0
22	V	10 Nursing and Medical Records		Petersen Health Enterprises, LLC	100.00%	0	0
23	V	15 Mgmt. Allocation of Benefits		Petersen Health Enterprises, LLC	100.00%	0	0
24	V	17 Administrative		Petersen Health Enterprises, LLC	100.00%	0	0
25	V	19 Professional Services		Petersen Health Enterprises, LLC	100.00%	819	819
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Enterprises, LLC	100.00%	12	12
27	V	21 Clerical and General Office		Petersen Health Enterprises, LLC	100.00%	1,295	1,295
28	V	22 Employee Benefits & Payroll		Petersen Health Enterprises, LLC	100.00%	4,954	4,954
29	V	23 Inservice Training & Education		Petersen Health Enterprises, LLC	100.00%	31	31
30	V	24 Travel and Seminar		Petersen Health Enterprises, LLC	100.00%	0	0
31	V	25 Other Admin. Staff Transport.		Petersen Health Enterprises, LLC	100.00%	0	0
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Enterprises, LLC	100.00%	303	303
33	V	27 Mgmt. Allocation of Benefits		Petersen Health Enterprises, LLC	100.00%	0	0
34	V	30 Depreciation		Petersen Health Enterprises, LLC	100.00%	0	0
35	V	32 Interest		Petersen Health Enterprises, LLC	100.00%	3,651	3,651
36	V	33 Real Estate Taxes		Petersen Health Enterprises, LLC	100.00%	0	0
37	V	34 Rent-Facility and Grounds		Petersen Health Enterprises, LLC	100.00%	0	0
38	V	35 Rent-Equipment & Vehicles		Petersen Health Enterprises, LLC	100.00%	0	0
39	Total		\$			\$ 11,065	\$ * 11,065

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

Facility Name & ID Number

Sheldon Health Care Center

0046573

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	70.00	See Schedule 7A	0.37	0.67	Salary	\$ 5,623	L17, C7	1
2	Jifi C. Jacob	Owner	Administrative	10.00	See Schedule 7A	0.38	0.69	Salary	371	L21, C7	2
3	Jacque Whitley	Owner	Administrative	10.00	See Schedule 7A	0.38	0.69	Salary	751	L21, C7	3
4	Cindy S. White	Owner	Administrative	10.00	See Schedule 7A	0.38	0.69	Salary	926	L21, C7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 7,671		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 Sheldon Health Care Center

0046573 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	9,027	\$ 755	1
2	2	Food	Resident Days	1,316,550	66	3,806	0	9,027	26	2
3	3	Housekeeping	Resident Days	1,316,550	66	1,250	0	9,027	9	3
4	4	Laundry	Resident Days	1,316,550	66	73	0	9,027	1	4
5	5	Utilities	Resident Days	1,316,550	66	18,812	0	9,027	129	5
6	6	Maintenance	Resident Days	1,316,550	66	153,468	113,063	9,027	1,052	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	50,271	0	9,027	345	7
8	10	Nursing and Medical Records	Resident Days	1,316,550	66	291,305	286,855	9,027	1,997	8
9	10A	Therapy	Resident Days	1,316,550	66	0	0	9,027	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	64,765	0	9,027	444	10
11	17	Administrative	Resident Days	1,316,550	66	820,116	820,116	9,027	5,623	11
12	19	Professional Services	Resident Days	1,316,550	66	222,628	0	9,027	1,526	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,316,550	66	48,243	0	9,027	331	13
14	21	Clerical and General Office	Resident Days	1,316,550	66	1,867,440	1,544,801	9,027	12,804	14
15	23	Inservice Training & Education	Resident Days	1,316,550	66	21,481	0	9,027	147	15
16	24	Travel and Seminar	Resident Days	1,316,550	66	34,177	0	9,027	234	16
17	25	Other Admin. Staff Transport.	Resident Days	1,316,550	66	123,847	0	9,027	849	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,316,550	66	50,427	0	9,027	346	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	533,953	0	9,027	3,661	19
20	30	Depreciation	Resident Days	1,316,550	66	130,767	0	9,027	897	20
21	32	Interest	Resident Days	1,316,550	66	227,295	0	9,027	1,558	21
22	33	Real Estate Taxes	Resident Days	1,316,550	66	43,090	0	9,027	295	22
23	34	Rent-Facility and Grounds	Resident Days	1,316,550	66	2,648	0	9,027	18	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,316,550	66	34,690	0	9,027	238	24
25	TOTALS					\$ 4,854,723	\$ 2,874,422		\$ 33,285	25

Facility Name & ID Number Sheldon Health Care Center

0046573 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

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

Name of Related Organization Petersen Health Enterprises, 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	86,155	5	\$	\$ 9,027	\$	1
2	2	Food	Resident Days	86,155	5		9,027		2
3	3	Housekeeping	Resident Days	86,155	5		9,027		3
4	4	Laundry	Resident Days	86,155	5		9,027		4
5	5	Utilities	Resident Days	86,155	5		9,027		5
6	6	Maintenance	Resident Days	86,155	5		9,027		6
7	7	Mgmt. Allocation of Benefits	Resident Days	86,155	5		9,027		7
8	10	Nursing and Medical Records	Resident Days	86,155	5		9,027		8
9	15	Mgmt. Allocation of Benefits	Resident Days	86,155	5		9,027		9
10	17	Administrative	Resident Days	86,155	5		9,027		10
11	19	Professional Services	Resident Days	86,155	5	7,818	9,027	819	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	86,155	5	110	9,027	12	12
13	21	Clerical and General Office	Resident Days	86,155	5	12,357	9,027	1,295	13
14	22	Employee Benefits & Payroll	Resident Days	86,155	5	47,280	9,027	4,954	14
15	23	Inservice Training & Education	Resident Days	86,155	5	300	9,027	31	15
16	24	Travel and Seminar	Resident Days	86,155	5		9,027		16
17	25	Other Admin. Staff Transport.	Resident Days	86,155	5		9,027		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	86,155	5	2,889	9,027	303	18
19	27	Mgmt. Allocation of Benefits	Resident Days	86,155	5		9,027		19
20	30	Depreciation	Resident Days	86,155	5		9,027		20
21	32	Interest	Resident Days	86,155	5	34,841	9,027	3,651	21
22	33	Real Estate Taxes	Resident Days	86,155	5		9,027		22
23	34	Rent-Facility and Grounds	Resident Days	86,155	5		9,027		23
24	35	Rent-Equipment & Vehicles	Resident Days	86,155	5		9,027		24
25	TOTALS					\$ 105,595	\$	\$ 11,065	25

Facility Name & ID Number

Sheldon Health Care Center

0046573

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	Sheldon Meadows		X	Mortgage	\$5,805.00	02/05/04	\$ 500,000	\$ 344,311	01/05/14	0.0700	\$ 25,783	1						
2												2						
3							Offset Interest Income				(563)	3						
4							Home Office Allocation-PHC				1,558	4						
5							Home Office Allocation-PHE				3,651	5						
Working Capital																		
6												6						
7												7						
8												8						
9	TOTAL Facility Related				\$5,805.00		\$ 500,000	\$ 344,311			\$ 30,429	9						
B. Non-Facility Related*																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 500,000	\$ 344,311			\$ 30,429	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.		\$	7,200	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	\$	7,211	2
3. Under or (over) accrual (line 2 minus line 1).		\$	11	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	7,500	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			295	
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.		\$	7,806	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002		8
	2003	6,161	9
	2004	7,309	10
	2005	7,091	11
	2006	7,211	12

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 Sheldon Health Care Center COUNTY Iroquois

FACILITY IDPH LICENSE NUMBER 0046573

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 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>25-C-27-02-253-001</u>	<u>Long-Term Care Facility</u>	\$ <u>7,211.00</u>	\$ <u>7,211.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>7,211.00</u>	\$ <u>7,211.00</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 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 Sheldon Health Care Center

0046573

Report Period Beginning:

01/01/2007 Ending:

12/31/2007

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 11,605 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

10 apartments are maintained on the nursing home grounds.

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

1. Total Amount Incurred: _____ 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>2004</u>	<u>\$ 29,250</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 29,250	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	31	2004		\$ 443,250	\$	25	\$ 17,730	\$ 17,730	\$ 65,010	4
5										5
6										6
7	Home Office Allocation			5,033			123	123		7
8										8
Improvement Type**										
9	Remodeling	2004		1,175		30	39	39	133	9
10	Landscaping Improvements	2005		1,375		15	92	92	222	10
11	Living room, lobby, hallway paint and border	2005		3,000		30	100	100	258	11
12	Flooring	2006		899		15	60	60	90	12
13	Roof	2006		2,015		25	81	81	121	13
14	Garage Door	2006		693		15	46	46	69	14
15	Watchmate	2006		6,435		5	1,287	1,287	1,931	15
16	Emergency System	2007		985		10	49	49	49	16
17	Carpet	2007		1,076		7	77	77	77	17
18										18
19										19
20										20
21					19,700			(19,700)		21
22	Building Booked				1,809			(1,809)		22
23	Building Improvement Booked									23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31	2007-Home Office Allocation-Building Improvements			337			20	20		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)	\$ 466,273	\$ 21,509		\$ 19,704	\$ (1,805)	\$ 67,960	70

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

Facility Name & ID Number Sheldon Health Care Center

0046573

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	\$ 190,827	\$ 27,681	\$ 27,626	\$ (55)	3-10	\$ 92,110	71
72	Current Year Purchases	595	59	30	(29)		30	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			754	754			74
75	TOTALS	\$ 191,422	\$ 27,740	\$ 28,410	\$ 670		\$ 92,140	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)	\$ 686,945	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 49,249	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 48,114	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (1,135)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 160,100	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Apartments & Land - 2004	\$ 52,500	\$	\$ 7,798	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 52,500	\$	\$ 7,798	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>18</u>			6
7	TOTAL				\$ <u>18</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: \$ 2,891 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.

Sheldon Health Care Center

0046573

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	\$ 2,640
Dishwasher	13
Home Office Allocation	<u>238</u>
	<u><u>2,891</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? <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		hrs	\$		\$			\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescripts				138		138	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			\$		\$	138		\$	138

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.

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (246,964)	1
2	Restatements (describe):		2
3	Rounding	3	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (246,961)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(149,010)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (149,010)	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)	\$ (395,971)	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	\$ 926,118	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 926,118	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,208	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 2,208	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	563	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 563	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	110	28
28a	Meals on Wheels Revenue	483	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 593	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 929,482	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	305,309	31
32	Health Care	396,700	32
33	General Administration	258,794	33
	B. Capital Expense		
34	Ownership	85,196	34
	C. Ancillary Expense		
35	Special Cost Centers	15,518	35
36	Provider Participation Fee	16,975	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,078,492	40
41	Income before Income Taxes (line 30 minus line 40)**	(149,010)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (149,010)	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 Sheldon Health Care Center

0046573

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	1,300	1,300	\$ 29,459	\$ 22.66	1
2	Assistant Director of Nursing	867	867	21,218	24.47	2
3	Registered Nurses	670	670	14,281	21.31	3
4	Licensed Practical Nurses	7,864	8,212	154,876	18.86	4
5	CNAs & Orderlies	13,315	13,905	128,634	9.25	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,920	2,088	26,513	12.70	9
10	Activity Assistants	297	297	2,089	7.03	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,109	2,141	22,107	10.33	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,356	6,701	56,324	8.41	15
16	Dishwashers					16
17	Maintenance Workers	1,296	1,344	19,137	14.24	17
18	Housekeepers	5,614	5,751	46,558	8.10	18
19	Laundry	1,968	1,968	14,047	7.14	19
20	Administrator	2,080	2,080	40,967	19.70	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Transportation</u>	9	9	57	6.33	33
34	TOTAL (lines 1 - 33)	45,665	47,333	\$ 576,267 *	\$ 12.17	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	7 hrs.	\$ 357	1(3)	35
36	Medical Director	Monthly	3,600	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	500	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 4,457		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	
Tina Gooding	Administrator	0	\$ 40,967	Workers' Compensation Insurance	\$ 8,272	IDPH License Fee	\$	
				Unemployment Compensation Insurance	11,353	Advertising: Employee Recruitment	451	
				FICA Taxes	43,248	Health Care Worker Background Check (Indicate # of checks performed)		
				Employee Health Insurance	88,808	Patient Background Checks	26	
				Employee Meals		Miscellaneous Dues & Subscriptions	124	
				Illinois Municipal Retirement Fund (IMRF)*		Home Office Allocation	343	
				Smoking Cessation	192	Miscellaneous Licenses & Permits	1,020	
				Employee Retirement	950	LTC Solutions License	1,600	
				Employee Relations	947	IHCA Dues	3,000	
						Less: Public Relations Expense	(89)	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 40,967	TOTAL (agree to Schedule V, line 22, col.8)		\$ 6,709		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 35,000				Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 35,000				Seminar Expense	0
C. Professional Services				TOTAL			Home Office Allocation	
Vendor/Payee	Type		Amount	\$			234	
E-Health Data Solutions	Computer Services		\$ 2,025				Entertainment Expense	
McGladrey & Pullen, LLP	Accounting Services		4,430				()	
Medi.com	Computer Services		959				TOTAL (agree to Sch. V, line 24, col. 8)	
							\$ 234	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 7,414					

* Attach copy of IMRF notifications

**See instructions.

Sheldon Health Care Center
0046573
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)		7,414

Home Office Allocation

Pearl & Associates	Legal	10
Addy Bush & Assoc	Legal	5
Registered Agent Solutions	Legal	1
Heyl, Royster, Voelker & Allen	Legal	22
Duane Morris	Legal	34
Ginoli & Co.	Accountants	1,168
RSM McGladrey	Accountants	60
McGladrey & Pullen	Accountants	92
Emdeon Business Services	Computer Services	24
Advanced Answers on Demand	Computer Services	647
Access 2 Go	Computer Services	49
Ivans	Computer Services	43
Kemper Technology	Computer Services	101
Adminastar Federal	Computer Services	13
Logmein	Computer Services	8
E-Health Data Solutions	Computer Services	63
Miscellaneous Vendors	Computer Services	5

Total (agree to Schedule V, line 19, column 8)		<u>9,759</u>
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Facility Name & ID Number Sheldon Health Care Center

0046573

Report Period Beginning: 01/01/2007

Ending: 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-\$3,000
- (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. \$ 1,654 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. \$ 16,975
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. \$ 2,208
- (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 & Company The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit still 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