

Facility Name & ID Number Sullivan Rehab & Health Care Center

0046425 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	123	Skilled (SNF)	123	44,895	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	123	TOTALS	123	44,895	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	18,359	7,914	3,011	29,284	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,359	7,914	3,011	29,284	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.23%

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)
Meals on Wheels

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 9/3/03

J. Was the facility purchased or leased after January 1, 1978?
YES Date 9/3/03 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 123 and days of care provided 2,996

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL 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 Sullivan Rehab & Health Care Center # 0046425 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	137,256	13,337	5,040	155,633		155,633	2,451	158,084		1
2	Food Purchase		149,871		149,871		149,871	(4,965)	144,906		2
3	Housekeeping	74,633	19,230		93,863		93,863	28	93,891		3
4	Laundry	50,896	12,572		63,468		63,468	2	63,470		4
5	Heat and Other Utilities			122,967	122,967		122,967	418	123,385		5
6	Maintenance	21,422	10,015	14,874	46,311		46,311	4,099	50,410		6
7	Other (specify):* <u>Home Off. Ben. All.</u>							1,118	1,118		7
8	TOTAL General Services	284,207	205,025	142,881	632,113		632,113	3,151	635,264		8
	B. Health Care and Programs										
9	Medical Director			9,000	9,000		9,000		9,000		9
10	Nursing and Medical Records	846,054	90,908	1,376	938,338		938,338	6,480	944,818		10
10a	Therapy	23,152		195,432	218,584		218,584		218,584		10a
11	Activities	22,766	633	4,587	27,986		27,986		27,986		11
12	Social Services	25,489			25,489		25,489		25,489		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Off. Ben. All.</u>							1,441	1,441		15
16	TOTAL Health Care and Programs	917,461	91,541	210,395	1,219,397		1,219,397	7,921	1,227,318		16
	C. General Administration										
17	Administrative	54,765		150,000	204,765		204,765	(131,758)	73,007		17
18	Directors Fees										18
19	Professional Services			9,508	9,508		9,508	8,292	17,800		19
20	Dues, Fees, Subscriptions & Promotions			9,952	9,952		9,952	75	10,027		20
21	Clerical & General Office Expenses	23,173	4,161	27,492	54,826		54,826	50,135	104,961		21
22	Employee Benefits & Payroll Taxes			149,643	149,643		149,643	9,592	159,235		22
23	Inservice Training & Education							504	504		23
24	Travel and Seminar							799	799		24
25	Other Admin. Staff Transportation			5,725	5,725		5,725	4,588	10,313		25
26	Insurance-Prop.Liab.Malpractice			16,530	16,530		16,530	2,883	19,413		26
27	Other (specify):* <u>Home Off. Ben. All.</u>							11,877	11,877		27
28	TOTAL General Administration	77,938	4,161	368,850	450,949		450,949	(43,013)	407,936		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,279,606	300,727	722,126	2,302,459		2,302,459	(31,941)	2,270,518		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 Sullivan Rehab & Health Care Center

#0046425

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			138,634	138,634		138,634	20,147	158,781			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			224,030	224,030		224,030	22,031	246,061			32
33	Real Estate Taxes			44,502	44,502		44,502	958	45,460			33
34	Rent-Facility & Grounds							59	59			34
35	Rent-Equipment & Vehicles			20,935	20,935		20,935	796	21,731			35
36	Other (specify):*											36
37	TOTAL Ownership			428,101	428,101		428,101	43,991	472,092			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		93,259		93,259		93,259		93,259			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			67,343	67,343		67,343		67,343			42
43	Other (specify):* Non-allowable Cost		1,138	134,649	135,787		135,787	(135,787)				43
44	TOTAL Special Cost Centers		94,397	201,992	296,389		296,389	(135,787)	160,602			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,279,606	395,124	1,352,219	3,026,949		3,026,949	(123,737)	2,903,212			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	(5,050)	2		4
5	Telephone, TV & Radio in Resident Rooms	(8,326)	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	267	30		9
10	Interest and Other Investment Income	(112)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(758)	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	(60)	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	(108,886)	43		24
25	Fund Raising, Advertising and Promotional	(4,492)	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	(15,259)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (142,676)		\$	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)	18,939	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 18,939		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (123,737)		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

Sullivan Rehab & Health Care Center

ID# 0046425

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (5,546)	43	1
2	X-Rays-Part A	(5,470)	43	2
3	Resident Flowers	(723)	43	3
4	Disallowed Special Events	(1,436)	43	4
5	Offset Miscellaneous Office Supplies Revenue	(219)	21	5
6	Offset Chamber of Commerce Dues	(1,775)	20	6
7	Vending Machine Expense	(90)	43	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(15,259)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sullivan Rehab & Health Care Center# 0046425

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	2,451	0	0	0	0	0	0	0	0	0	2,451	1
2	Food Purchase	(5,050)	85	0	0	0	0	0	0	0	0	0	(4,965)	2
3	Housekeeping	0	28	0	0	0	0	0	0	0	0	0	28	3
4	Laundry	0	2	0	0	0	0	0	0	0	0	0	2	4
5	Heat and Other Utilities	0	418	0	0	0	0	0	0	0	0	0	418	5
6	Maintenance	0	3,414	0	685	0	0	0	0	0	0	0	4,099	6
7	Other (specify):*	0	1,118	0	0	0	0	0	0	0	0	0	1,118	7
8	TOTAL General Services	(5,050)	7,516	0	685	0	3,151	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	6,480	0	0	0	0	0	0	0	0	0	6,480	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	1,441	0	0	0	0	0	0	0	0	0	1,441	15
16	TOTAL Health Care and Programs	0	7,921	0	0	0	0	0	0	0	0	0	7,921	16
	C. General Administration													
17	Administrative	0	(131,758)	0	0	0	0	0	0	0	0	0	(131,758)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	4,952	0	3,340	0	0	0	0	0	0	0	8,292	19
20	Fees, Subscriptions & Promotions	(1,775)	0	1,073	777	0	0	0	0	0	0	0	75	20
21	Clerical & General Office Expenses	(219)	0	41,537	8,817	0	0	0	0	0	0	0	50,135	21
22	Employee Benefits & Payroll Taxes	0	0	0	9,592	0	0	0	0	0	0	0	9,592	22
23	Inservice Training & Education	0	0	478	26	0	0	0	0	0	0	0	504	23
24	Travel and Seminar	0	0	760	39	0	0	0	0	0	0	0	799	24
25	Other Admin. Staff Transportation	0	0	2,755	1,833	0	0	0	0	0	0	0	4,588	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,122	1,761	0	0	0	0	0	0	0	2,883	26
27	Other (specify):*	0	0	11,877	0	0	0	0	0	0	0	0	11,877	27
28	TOTAL General Administration	(1,994)	(126,806)	59,602	26,185	0	(43,013)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(7,044)	(111,369)	59,602	26,870	0	(31,941)	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sullivan Rehab & Health Care Center# 0046425

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	267	0	2,909	16,971	0	0	0	0	0	0	0	20,147	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(112)	0	5,056	17,087	0	0	0	0	0	0	0	22,031	32
33	Real Estate Taxes	0	0	958	0	0	0	0	0	0	0	0	958	33
34	Rent-Facility & Grounds	0	0	59	0	0	0	0	0	0	0	0	59	34
35	Rent-Equipment & Vehicles	0	0	772	24	0	0	0	0	0	0	0	796	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	155	0	9,754	34,082	0	43,991	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):*	(135,787)	0	0	0	0	0	0	0	0	0	0	(135,787)	43
44	TOTAL Special Cost Centers	(135,787)	0	0	0	0	0	0	0	0	0	0	(135,787)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(142,676)	(111,369)	69,356	60,952	0	(123,737)	45						

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark Petersen	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%	\$ 2,451	\$ 2,451	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	85	85	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	28	28	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	2	2	4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	418	418	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	3,414	3,414	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,118	1,118	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	6,480	6,480	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%	1,441	1,441	10
11	V	17 Administrative	150,000	Petersen Health Care, Inc.	100.00%	18,242	(131,758)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	4,952	4,952	12
13	V							13
14	Total		\$ 150,000			\$ 38,631	\$ * (111,369)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	20 Dues, Fees, Subs and Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 1,073	\$	1,073	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	41,537		41,537	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	478		478	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	760		760	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	2,755		2,755	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	1,122		1,122	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	11,877		11,877	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	2,909		2,909	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	5,056		5,056	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	958		958	24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	59		59	25
26	V	35 Rent-Equipment and Vehicles		Petersen Health Care, Inc.	100.00%	772		772	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		\$			\$ 69,356	\$ *	69,356	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 0	\$ 0
16	V	2 Food		Petersen Health Care, Inc.	100.00%	0	0
17	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	0	0
18	V	4 Laundry		Petersen Health Care, Inc.	100.00%	0	0
19	V	5 Utilities		Petersen Health Care, Inc.	100.00%	0	0
20	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	685	685
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0	0
22	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	0	0
23	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0	0
24	V	17 Administrative		Petersen Health Care, Inc.	100.00%	0	0
25	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	3,340	3,340
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Care, Inc.	100.00%	777	777
27	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	8,817	8,817
28	V	22 Employee Benefits & Payroll		Petersen Health Care, Inc.	100.00%	9,592	9,592
29	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	26	26
30	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	39	39
31	V	25 Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	1,833	1,833
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	1,761	1,761
33	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0	0
34	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	16,971	16,971
35	V	32 Interest		Petersen Health Care, Inc.	100.00%	17,087	17,087
36	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	0	0
37	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0	0
38	V	35 Rent-Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	24	24
39	Total		\$			\$ 60,952	\$ * 60,952

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

Facility Name & ID Number Sullivan Rehab & Health Care Center # 0046425 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	1.2	2.18	Salary	\$ 18,242	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	\$ 18,242		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 Sullivan Rehab & Health Care Center

0046425

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	29,284	\$ 2,451	1
2	2	Food	Resident Days	1,316,550	66	3,806	0	29,284	85	2
3	3	Housekeeping	Resident Days	1,316,550	66	1,250	0	29,284	28	3
4	4	Laundry	Resident Days	1,316,550	66	73	0	29,284	2	4
5	5	Utilities	Resident Days	1,316,550	66	18,812	0	29,284	418	5
6	6	Maintenance	Resident Days	1,316,550	66	153,468	113,063	29,284	3,414	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	50,271	0	29,284	1,118	7
8	10	Nursing and Medical Records	Resident Days	1,316,550	66	291,305	286,855	29,284	6,480	8
9	15	Therapy	Resident Days	1,316,550	66	0	0	29,284	0	9
10	17	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	64,765	0	29,284	1,441	10
11	19	Administrative	Resident Days	1,316,550	66	820,116	820,116	29,284	18,242	11
12	20	Professional Services	Resident Days	1,316,550	66	222,628	0	29,284	4,952	12
13	21	Dues, Fees, Subs & Promotions	Resident Days	1,316,550	66	48,243	0	29,284	1,073	13
14	22	Clerical and General Office	Resident Days	1,316,550	66	1,867,440	1,544,801	29,284	41,537	14
15	23	Inservice Training & Education	Resident Days	1,316,550	66	21,481	0	29,284	478	15
16	24	Travel and Seminar	Resident Days	1,316,550	66	34,177	0	29,284	760	16
17	25	Other Admin. Staff Transport.	Resident Days	1,316,550	66	123,847	0	29,284	2,755	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,316,550	66	50,427	0	29,284	1,122	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	533,953	0	29,284	11,877	19
20	30	Depreciation	Resident Days	1,316,550	66	130,767	0	29,284	2,909	20
21	32	Interest	Resident Days	1,316,550	66	227,295	0	29,284	5,056	21
22	33	Real Estate Taxes	Resident Days	1,316,550	66	43,090	0	29,284	958	22
23	34	Rent-Facility and Grounds	Resident Days	1,316,550	66	2,648	0	29,284	59	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,316,550	66	34,690	0	29,284	772	24
25	TOTALS					\$ 4,854,723	\$ 2,874,422		\$ 107,987	25

Facility Name & ID Number Sullivan Rehab & Health Care Center# 0046425 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 Care II, Inc.
 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	340,686	11	\$	29,284	\$	1
2	2	Food	Resident Days	340,686	11		29,284		2
3	3	Housekeeping	Resident Days	340,686	11		29,284		3
4	4	Laundry	Resident Days	340,686	11		29,284		4
5	5	Utilities	Resident Days	340,686	11		29,284		5
6	6	Maintenance	Resident Days	340,686	11	7,966	29,284	685	6
7	7	Mgmt. Allocation of Benefits	Resident Days	340,686	11		29,284		7
8	10	Nursing and Medical Records	Resident Days	340,686	11		29,284		8
9	15	Mgmt. Allocation of Benefits	Resident Days	340,686	11		29,284		9
10	17	Administrative	Resident Days	340,686	11		29,284		10
11	19	Professional Services	Resident Days	340,686	11	38,857	29,284	3,340	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	340,686	11	9,036	29,284	777	12
13	21	Clerical and General Office	Resident Days	340,686	11	102,581	29,284	8,817	13
14	22	Employee Benefits & Payroll	Resident Days	340,686	11	111,591	29,284	9,592	14
15	23	Inservice Training & Education	Resident Days	340,686	11	300	29,284	26	15
16	24	Travel and Seminar	Resident Days	340,686	11	451	29,284	39	16
17	25	Other Admin. Staff Transport.	Resident Days	340,686	11	21,324	29,284	1,833	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	340,686	11	20,484	29,284	1,761	18
19	27	Mgmt. Allocation of Benefits	Resident Days	340,686	11		29,284		19
20	30	Depreciation	Resident Days	340,686	11	197,442	29,284	16,971	20
21	32	Interest	Resident Days	340,686	11	198,787	29,284	17,087	21
22	33	Real Estate Taxes	Resident Days	340,686	11		29,284		22
23	34	Rent-Facility and Grounds	Resident Days	340,686	11		29,284		23
24	35	Rent-Equipment & Vehicles	Resident Days	340,686	11	280	29,284	24	24
25	TOTALS					\$ 709,099	\$	\$ 60,952	25

Facility Name & ID Number Sullivan Rehab & Health Care Center

0046425

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	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	U.S. Bank		X	Mortgage	\$40,714+ int.	12/10/04	\$ 3,420,000	\$ 3,165,897	12/10/11	0.0699	\$ 224,030	1								
2												2								
3							Interest Income Offset				(112)	3								
4							Home Office Allocation-PHC				5,056	4								
5							Home Office Allocation-PHC II				17,087	5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related						\$ 3,420,000	\$ 3,165,897			\$ 246,061	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 3,420,000	\$ 3,165,897			\$ 246,061	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.		\$	43,600	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	\$	43,102	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(498)	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	45,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. Home Office Allocation			958	
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.		\$	45,460	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002		8
	2003	14,612	9
	2004	42,434	10
	2005	43,662	11
	2006	43,102	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 Sullivan Rehab & Health Care Center COUNTY Moultrie

FACILITY IDPH LICENSE NUMBER 0046425

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>08-08-11-400-004</u>	<u>Long-Term Care Facility</u>	\$ <u>43,046.00</u>	\$ <u>43,046.00</u>
2. <u>08-08-12-300-004</u>	<u>Long-Term Care Facility</u>	\$ <u>56.00</u>	\$ <u>56.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>43,102.00</u>	\$ <u>43,102.00</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 Sullivan Rehab & Health Care Center

0046425

Report Period Beginning:

01/01/2007 Ending:

12/31/2007

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,000 B. General Construction Type: Exterior Brick & Block Frame Concrete 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>334,095</u>	<u>2003</u>	<u>\$ 100,001</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	334,095		\$ 100,001	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	123	2003	1975	\$ 1,560,545	\$	39	\$ 40,014	\$ 40,014	\$ 173,394	4
5										5
6										6
7	Home Office Allocation			16,326			399	399		7
8										8
Improvement Type**										
9	Carpeting		2004	4,808		25	192	192	624	9
10	Fire Alarms		2004	1,524		25	61	61	173	10
11	Doors		2004	3,067		5	613	613	2,095	11
12	Smoke Alarms		2004	1,227		7	175	175	514	12
13	Land Improvements		2006	7,262		15	484	484	726	13
14	New Roof		2006	28,308		25	1,132	1,132	1,698	14
15	Kitchen Remodel		2006	22,241		25	890	890	1,335	15
16	Landscaping		2006	2,434		15	162	162	243	16
17	Sidewalks		2007	1,785		15	60	60	60	17
18										18
19										19
20										20
21										21
22					40,014			(40,014)		22
23	Building Booked				3,013			(3,013)		23
24	Building Improvement Booked									24
25										25
26										26
27										27
28										28
29										29
30										30
31	2007-Home Office Allocation-Building Improvements			1,092			65	65		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)	\$ 1,650,619	\$ 43,027		\$ 44,247	\$ 1,220	\$ 180,862	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	\$ 620,120	\$ 88,533	\$ 88,374	\$ (159)	5-15	\$ 313,054	71
72	Current Year Purchases	10,413	851	521	(330)	10	521	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			19,416	19,416			74
75	TOTALS	\$ 630,533	\$ 89,384	\$ 108,311	\$ 18,927		\$ 313,575	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	2003 Ford	2003	\$ 31,116	\$ 6,223	\$ 6,223	\$	5	\$ 25,930	76
77										77
78										78
79										79
80	TOTALS			\$ 31,116	\$ 6,223	\$ 6,223	\$		\$ 25,930	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,412,269	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 138,634	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 158,781	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 20,147	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 520,367	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>59</u>			6
7	TOTAL				\$ <u>59</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: \$ 21,731 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.

Sullivan Rehab & Health Care Center

0046425

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	\$ 15,102
Dishwasher	906
Laundry Equipment	90
Copier	4,837
Home Office Allocation	796
	<u>21,731</u>

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	5,105	\$ 76,568	\$	5,105	\$ 76,568	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,832	27,476		1,832	27,476	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		6,093	91,388		6,093	91,388	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				93,259		93,259	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			\$	13,030	\$ 195,432	\$ 93,259	13,030	\$ 288,691	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 Sullivan Rehab & Health Care Center

0046425

Report Period Beginning: 01/01/2007

Ending:

12/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 3,344,619	\$ 3,344,619	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>N/A</u>)	559,362	559,362	3
4	Supply Inventory (priced at <u> </u>)			4
5	Short-Term Investments			5
6	Prepaid Insurance	18,327	18,327	6
7	Other Prepaid Expenses	6,333	6,333	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u> </u>			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,928,641	\$ 3,928,641	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	111,481	100,001	13
14	Buildings, at Historical Cost	1,560,545	1,576,871	14
15	Leasehold Improvements, at Historical Cost	56,880	73,748	15
16	Equipment, at Historical Cost	665,945	661,649	16
17	Accumulated Depreciation (book methods)	(591,788)	(520,367)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify): <u> </u>			22
23	Other(specify): <u> </u>			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,803,063	\$ 1,891,902	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,731,704	\$ 5,820,543	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 365,111	\$ 365,111	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	99,337	99,337	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,508	5,508	31
32	Accrued Real Estate Taxes(Sch.IX-B)	45,000	45,000	32
33	Accrued Interest Payable	18,441	18,441	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	24,825	24,825	36
37	<u>Due to Related Parties</u>	6,114	6,114	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 564,336	\$ 564,336	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	3,165,897	3,165,897	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>A/P-Prior Owner</u>	20,943	20,943	43
44	<u> </u>			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,186,840	\$ 3,186,840	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,751,176	\$ 3,751,176	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,980,528	\$ 2,069,367	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,731,704	\$ 5,820,543	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,241,393	1
2	Restatements (describe):		2
3	Post Cost Report Audit Adjustments	(25,185)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,216,208	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	764,320	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)	\$ 764,320	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)	\$ 1,980,528	24 *

* This must agree with page 17, line 47.

Sullivan Rehab & Health Care Center
0046425
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	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,088,297	1
2	Discounts and Allowances for all Levels	176,981	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,265,278	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	326,704	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 326,704	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	5,050	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	172,921	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	6,688	20
21	Other Medical Services	8,890	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 193,549	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	112	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 112	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Meals on Wheels Revenue</u>	5,407	28
28a	<u>Miscellaneous Income</u>	219	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 5,626	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,791,269	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	632,113	31
32	Health Care	1,219,397	32
33	General Administration	450,949	33
	B. Capital Expense		
34	Ownership	428,101	34
	C. Ancillary Expense		
35	Special Cost Centers	229,046	35
36	Provider Participation Fee	67,343	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,026,949	40
41	Income before Income Taxes (line 30 minus line 40)**	764,320	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 764,320	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 Sullivan Rehab & Health Care Center

0046425

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	2,122	\$ 51,672	\$ 24.35	1
2	Assistant Director of Nursing	1,213	23,866	19.68	2
3	Registered Nurses	7,483	164,864	21.47	3
4	Licensed Practical Nurses	8,896	154,577	16.76	4
5	CNAs & Orderlies	37,432	382,732	9.94	5
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides	1,787	23,152	11.86	8
9	Activity Director	1,944	22,766	10.82	9
10	Activity Assistants				10
11	Social Service Workers	2,048	25,489	12.25	11
12	Dietician				12
13	Food Service Supervisor	2,008	32,502	15.63	13
14	Head Cook				14
15	Cook Helpers/Assistants	12,727	104,754	7.92	15
16	Dishwashers				16
17	Maintenance Workers	2,011	21,422	10.32	17
18	Housekeepers	9,242	74,633	7.88	18
19	Laundry	6,235	50,896	7.82	19
20	Administrator	1,995	54,765	26.39	20
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager	2,080	23,173	11.14	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	1,981	21,431	10.03	31
32	Other Health C: <u>Care Plan Coord.</u>	2,577	46,912	18.15	32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	103,781	\$ 1,279,606 *	\$ 11.95	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	96 hrs.	\$ 5,040	1(3) 35
36	Medical Director	Monthly	9,000	9(3) 36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly	1,100	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)		\$ 15,140	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	
<u>Laura Northway</u>	<u>Administrator</u>	<u>0</u>	\$ <u>44,236</u>	<u>Workers' Compensation Insurance</u>	\$ <u>18,906</u>	<u>IDPH License Fee</u>	\$ _____	
<u>Brenda Winskill</u>	<u>Administrator</u>	<u>0</u>	<u>10,529</u>	<u>Unemployment Compensation Insurance</u>	<u>33,046</u>	<u>Advertising: Employee Recruitment</u>	<u>1,057</u>	
				<u>FICA Taxes</u>	<u>100,861</u>	<u>Health Care Worker Background Check</u>		
				<u>Employee Health Insurance</u>	<u>1,424</u>	(Indicate # of checks performed)		
				<u>Employee Meals</u>		<u>Patient Background Checks</u>	<u>162</u>	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Miscellaneous Dues & Subscriptions</u>	<u>1,775</u>	
				<u>Physicals</u>	<u>1,734</u>	<u>Home Office Allocation</u>	<u>1,850</u>	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ <u>54,765</u>	<u>Employee Retirement</u>	<u>2,388</u>	<u>Misc. Licenses & Permits</u>	<u>150</u>	
(List each licensed administrator separately.)				<u>Smoking Cessation</u>	<u>59</u>	<u>LTC Solutions License</u>	<u>1,600</u>	
				<u>Employee Relations</u>	<u>817</u>	<u>IHCA Dues</u>	<u>3,750</u>	
						<u>Less: Public Relations Expense</u>	<u>(1,775)</u>	
						<u>Non-allowable advertising</u>	(_____)	
						<u>Yellow page advertising</u>	(_____)	
				TOTAL (agree to Schedule V, line 22, col.8)	\$ <u>159,235</u>	TOTAL (agree to Sch. V, line 20, col. 8)	\$ <u>10,027</u>	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ <u>150,000</u>	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
(Attach a copy of any management service agreement)				Description	Line #	Amount	Description	Amount
							<u>Out-of-State Travel</u>	\$ _____
				<u>N/A</u>			<u>In-State Travel</u>	
							<u>Seminar Expense</u>	
							<u>Home Office Allocation</u>	<u>799</u>
							<u>Entertainment Expense</u>	(_____)
TOTAL (agree to Schedule V, line 19, column 3)			\$ <u>9,508</u>	TOTAL		\$ _____	TOTAL (agree to Sch. V, line 24, col. 8)	\$ <u>799</u>
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications

**See instructions.

Sullivan Rehab & Health Care Center

0046425

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)		9,508

Home Office Allocation

Pearl & Associates	Legal	32
Addy Bush & Assoc	Legal	16
Registered Agent Solutions	Legal	3
Heyl, Royster, Voelker & Allen	Legal	72
Duane Morris	Legal	111
Ginoli & Co.	Accountants	3,708
RSM McGladrey	Accountants	196
McGladrey & Pullen	Accountants	299
Emdeon Business Services	Computer Services	78
Advanced Answers on Demand	Computer Services	2,100
Access 2 Go	Computer Services	158
Ivans	Computer Services	686
Kemper Technology	Computer Services	329
Adminastar Federal	Computer Services	41
Logmein	Computer Services	26
E-Health Data Solutions	Computer Services	206
Miscellaneous Vendors	Computer Services	14
CDW	Computer Services	165
Miscellaneous Vendors	Professional Services	52

Total (agree to Schedule V, line 19, column 8)		<u>17,800</u>
--	--	---------------

Facility Name & ID Number Sullivan Rehab & Health Care Center

0046425

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-\$3,750
- (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. \$ 12,466 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. \$ 67,343
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. \$ 5,050
- (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