

Facility Name & ID Number Sheldon Health Care Center

0046573 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

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	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	8,880	1,053	168	10,101	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,880	1,053	168	10,101	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.27%

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 Building Units, 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 1/1/2004

J. Was the facility purchased or leased after January 1, 1978?
 YES Date 1/1/2004 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: 12/31/2009 Fiscal Year: 12/31/2009

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

Facility Name & ID Number

Sheldon Health Care Center

0046573

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

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	80,442	6,468		86,910		86,910	(14,441)	72,469		1
2	Food Purchase		68,828		68,828		68,828	(18,436)	50,392		2
3	Housekeeping	52,692	8,696		61,388		61,388	(11,723)	49,665		3
4	Laundry	8,151	4,755		12,906		12,906	(2,469)	10,437		4
5	Heat and Other Utilities			37,162	37,162		37,162	(6,893)	30,269		5
6	Maintenance	15,790	4,927	18,008	38,725		38,725	(6,350)	32,375		6
7	Other (specify):* Home Off. Ben. All.							394	394		7
8	TOTAL General Services	157,075	93,674	55,170	305,919		305,919	(59,918)	246,001		8
	B. Health Care and Programs										
9	Medical Director			3,600	3,600		3,600		3,600		9
10	Nursing and Medical Records	372,175	18,162	373	390,710		390,710	1,322	392,032		10
10a	Therapy										10a
11	Activities	28,410	219	500	29,129		29,129		29,129		11
12	Social Services										12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.							163	163		15
16	TOTAL Health Care and Programs	400,585	18,381	4,473	423,439		423,439	1,485	424,924		16
	C. General Administration										
17	Administrative	10,375		40,000	50,375		50,375	(7,144)	43,231		17
18	Directors Fees										18
19	Professional Services			9,004	9,004		9,004	4,452	13,456		19
20	Dues, Fees, Subscriptions & Promotions			4,092	4,092		4,092	2,307	6,399		20
21	Clerical & General Office Expenses		4,262	6,044	10,306		10,306	25,698	36,004		21
22	Employee Benefits & Payroll Taxes			100,494	100,494		100,494	193	100,687		22
23	Inservice Training & Education			200	200		200	227	427		23
24	Travel and Seminar							70	70		24
25	Other Admin. Staff Transportation			1,355	1,355		1,355	1,098	2,453		25
26	Insurance-Prop.Liab.Malpractice			32,631	32,631		32,631	455	33,086		26
27	Other (specify):* Home Off. Ben. All.							5,979	5,979		27
28	TOTAL General Administration	10,375	4,262	193,820	208,457		208,457	33,335	241,792		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	568,035	116,317	253,463	937,815		937,815	(25,098)	912,717		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:

1/1/2009

Ending:

12/31/2009

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			50,418	50,418		50,418	2,733	53,151			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			19,210	19,210		19,210	14,079	33,289			32
33	Real Estate Taxes			7,283	7,283		7,283	277	7,560			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			68	68		68	265	333			35
36	Other (specify):*											36
37	TOTAL Ownership			76,979	76,979		76,979	17,354	94,333			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			16,973	16,973		16,973		16,973			42
43	Other (specify):* Non-allowable Cost		274	10,173	10,447		10,447	(10,447)				43
44	TOTAL Special Cost Centers		274	27,146	27,420		27,420	(10,447)	16,973			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	568,035	116,591	357,588	1,042,214		1,042,214	(18,191)	1,024,023			45

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

Sheldon Health Care Center

ID# 0046573

Report Period Beginning: 1/1/2009

Ending: 12/31/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Resident Flowers	\$ (502)	43	1
2	Disallowed Special Events	(314)	43	2
3	Offset Miscellaneous Office Supplies Revenue	(146)	21	3
4	Offset Meals on Wheels Revenue	(3,098)	2	4
5	Offset Independent Living Dietary	(16,626)	1	5
6	Offset Independent Living Food	(13,167)	2	6
7	Offset Independent Living Housekeeping	(11,744)	3	7
8	Offset Independent Living Laundry	(2,469)	4	8
9	Offset Independent Living Utilities	(7,109)	5	9
10	Offset Independent Living Maintenance	(7,408)	6	10
11	Offset Independent Living Depreciation	(1,970)	30	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	(64,553)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sheldon Health Care Center# 0046573

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

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)	
	A. General Services													
1	Dietary	(16,626)	2,185	0	0	0	0	0	0	0	0	0	(14,441)	1
2	Food Purchase	(18,485)	49	0	0	0	0	0	0	0	0	0	(18,436)	2
3	Housekeeping	(11,744)	21	0	0	0	0	0	0	0	0	0	(11,723)	3
4	Laundry	(2,469)	0	0	0	0	0	0	0	0	0	0	(2,469)	4
5	Heat and Other Utilities	(7,109)	216	0	0	0	0	0	0	0	0	0	(6,893)	5
6	Maintenance	(7,408)	1,058	0	0	0	0	0	0	0	0	0	(6,350)	6
7	Other (specify):*	0	394	0	0	0	0	0	0	0	0	0	394	7
8	TOTAL General Services	(63,841)	3,923	0	0	0	0	0	0	0	0	0	(59,918)	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	1,322	0	0	0	0	0	0	0	0	0	1,322	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	163	0	0	0	0	0	0	0	0	0	163	15
16	TOTAL Health Care and Programs	0	1,485	0	0	0	0	0	0	0	0	0	1,485	16
	C. General Administration													
17	Administrative	0	(7,144)	0	0	0	0	0	0	0	0	0	(7,144)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	3,063	0	1,389	0	0	0	0	0	0	0	4,452	19
20	Fees, Subscriptions & Promotions	0	0	854	1,453	0	0	0	0	0	0	0	2,307	20
21	Clerical & General Office Expenses	(146)	0	22,276	3,568	0	0	0	0	0	0	0	25,698	21
22	Employee Benefits & Payroll Taxes	0	0	0	193	0	0	0	0	0	0	0	193	22
23	Inservice Training & Education	0	0	227	0	0	0	0	0	0	0	0	227	23
24	Travel and Seminar	0	0	70	0	0	0	0	0	0	0	0	70	24
25	Other Admin. Staff Transportation	0	0	1,098	0	0	0	0	0	0	0	0	1,098	25
26	Insurance-Prop.Liab.Malpractice	0	0	455	0	0	0	0	0	0	0	0	455	26
27	Other (specify):*	0	0	5,979	0	0	0	0	0	0	0	0	5,979	27
28	TOTAL General Administration	(146)	(4,081)	30,959	6,603	0	33,335	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(63,987)	1,327	30,959	6,603	0	(25,098)	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sheldon Health Care Center# 0046573

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	(1,361)	0	1,801	2,293	0	0	0	0	0	0	0	2,733	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(52)	0	2,769	11,362	0	0	0	0	0	0	0	14,079	32
33	Real Estate Taxes	0	0	277	0	0	0	0	0	0	0	0	277	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	265	0	0	0	0	0	0	0	0	265	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(1,413)	0	5,112	13,655	0	17,354	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):*	(10,447)	0	0	0	0	0	0	0	0	0	0	(10,447)	43
44	TOTAL Special Cost Centers	(10,447)	0	0	0	0	0	0	0	0	0	0	(10,447)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(75,847)	1,327	36,071	20,258	0	(18,191)	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	65	See Attached Schedule 6E		See Attached Sch 6E		
Jifi Jacob	10					
Cindy S. White	10					
Jacque Whitley	10					
David Petersen	5					

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%	\$ 2,185	\$ 2,185	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	49	49	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	21	21	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	216	216	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	1,058	1,058	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	394	394	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	1,322	1,322	8
9	V	11 Activities		Petersen Health Care, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	163	163	10
11	V	17 Administrative	40,000	Petersen Health Care, Inc.	100.00%	32,856	(7,144)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	3,063	3,063	12
13	V							13
14	Total		\$ 40,000			\$ 41,327	\$ * 1,327	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%	\$ 854	\$ 854	15	
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	22,276	22,276	16	
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	227	227	17	
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	70	70	18	
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	1,098	1,098	19	
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	455	455	20	
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	5,979	5,979	21	
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	1,801	1,801	22	
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	2,769	2,769	23	
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	277	277	24	
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0		25	
26	V	35 Rent-Equipment and Vehicles		Petersen Health Care, Inc.	100.00%	265	265	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		\$			\$ 36,071	\$ *	36,071	39

* 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: 1/1/2009

Ending: 12/31/2009

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	\$	15
16	V	2	Food		Petersen Health Enterprises, LLC	100.00%	0		16
17	V	3	Housekeeping		Petersen Health Enterprises, LLC	100.00%	0		17
18	V	4	Laundry		Petersen Health Enterprises, LLC	100.00%	0		18
19	V	5	Utilities		Petersen Health Enterprises, LLC	100.00%	0		19
20	V	6	Maintenance		Petersen Health Enterprises, LLC	100.00%	0		20
21	V	7	Mgmt. Allocation of Benefits		Petersen Health Enterprises, LLC	100.00%	0		21
22	V	10	Nursing and Medical Records		Petersen Health Enterprises, LLC	100.00%	0		22
23	V	15	Mgmt. Allocation of Benefits		Petersen Health Enterprises, LLC	100.00%	0		23
24	V	17	Administrative		Petersen Health Enterprises, LLC	100.00%	0		24
25	V	19	Professional Services		Petersen Health Enterprises, LLC	100.00%	1,389		1,389 25
26	V	20	Dues, Fees, Subs & Promotions		Petersen Health Enterprises, LLC	100.00%	1,453		1,453 26
27	V	21	Clerical and General Office		Petersen Health Enterprises, LLC	100.00%	3,568		3,568 27
28	V	22	Employee Benefits & Payroll		Petersen Health Enterprises, LLC	100.00%	193		193 28
29	V	23	Inservice Training & Education		Petersen Health Enterprises, LLC	100.00%	0		29
30	V	24	Travel and Seminar		Petersen Health Enterprises, LLC	100.00%	0		30
31	V	25	Other Admin. Staff Transport.		Petersen Health Enterprises, LLC	100.00%	0		31
32	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Enterprises, LLC	100.00%	0		32
33	V	27	Mgmt. Allocation of Benefits		Petersen Health Enterprises, LLC	100.00%	0		33
34	V	30	Depreciation		Petersen Health Enterprises, LLC	100.00%	2,293		2,293 34
35	V	32	Interest		Petersen Health Enterprises, LLC	100.00%	11,362		11,362 35
36	V	33	Real Estate Taxes		Petersen Health Enterprises, LLC	100.00%	0		36
37	V	34	Rent-Facility and Grounds		Petersen Health Enterprises, LLC	100.00%	0		37
38	V	35	Rent-Equipment & Vehicles		Petersen Health Enterprises, LLC	100.00%	0		38
39	Total			\$			\$ 20,258	\$ *	20,258 39

* 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:

1/1/2009

Ending:

12/31/2009

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	65.00	157,693	0.49	0.81	Salary	1,420	L17, C7	1
2	Jifi C. Jacob	Owner	Administrative	10.00	63,500			Salary			2
3	Jacque Whitley	Owner	Administrative	10.00	104,511	0.50	0.84	Salary	941	L10, C7	3
4	Cindy S. White	Owner	Administrative	10.00	111,734	0.49	0.81	Salary	1,006	L21, C7	4
5	David Petersen	Owner	Administrative	5.00	0			Salary			5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 3,367		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:

1/1/2009

Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Petersen Health Care, Inc.
 Street Address 830 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	1,493,044	75	\$ 261,102	\$ 259,584	12,492	\$ 2,185	1
2	2	Food	Resident Days	1,493,044	75	5,864	0	12,492	49	2
3	3	Housekeeping	Resident Days	1,493,044	75	2,458	0	12,492	21	3
4	4	Laundry	Resident Days	1,493,044	75	0	0	12,492	0	4
5	5	Utilities	Resident Days	1,493,044	75	25,776	0	12,492	216	5
6	6	Maintenance	Resident Days	1,493,044	75	126,463	107,810	12,492	1,058	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	47,148	0	12,492	394	7
8	10	Nursing and Medical Records	Resident Days	1,493,044	75	158,020	151,697	12,492	1,322	8
9	10A	Therapy	Resident Days	1,493,044	75	0	0	12,492	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	19,462	0	12,492	163	10
11	17	Administrative	Resident Days	1,493,044	75	3,315,953	3,315,953	12,492	32,856	11
12	19	Professional Services	Resident Days	1,493,044	75	366,089	0	12,492	3,063	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,493,044	75	102,022	0	12,492	854	13
14	21	Clerical and General Office	Resident Days	1,493,044	75	2,662,394	2,253,243	12,492	22,276	14
15	23	Inservice Training & Education	Resident Days	1,493,044	75	27,176	0	12,492	227	15
16	24	Travel and Seminar	Resident Days	1,493,044	75	8,381	0	12,492	70	16
17	25	Other Admin. Staff Transport.	Resident Days	1,493,044	75	131,200	0	12,492	1,098	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,493,044	75	54,425	0	12,492	455	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	714,650	0	12,492	5,979	19
20	30	Depreciation	Resident Days	1,493,044	75	215,197	0	12,492	1,801	20
21	32	Interest	Resident Days	1,493,044	75	330,981	0	12,492	2,769	21
22	33	Real Estate Taxes	Resident Days	1,493,044	75	33,065	0	12,492	277	22
23	34	Rent-Facility and Grounds	Resident Days	1,493,044	75	0	0	12,492	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,493,044	75	31,635	0	12,492	265	24
25	TOTALS					\$ 8,639,461	\$ 6,088,287		\$ 77,398	25

Facility Name & ID Number Sheldon Health Care Center

0046573

Report Period Beginning:

1/1/2009

Ending: 2/31/2009

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	93,320	5	\$	\$	12,492	\$	1
2	2	Food	Resident Days	93,320	5			12,492		2
3	3	Housekeeping	Resident Days	93,320	5			12,492		3
4	4	Laundry	Resident Days	93,320	5			12,492		4
5	5	Utilities	Resident Days	93,320	5			12,492		5
6	6	Maintenance	Resident Days	93,320	5			12,492		6
7	7	Mgmt. Allocation of Benefits	Resident Days	93,320	5			12,492		7
8	10	Nursing and Medical Records	Resident Days	93,320	5			12,492		8
9	15	Mgmt. Allocation of Benefits	Resident Days	93,320	5			12,492		9
10	17	Administrative	Resident Days	93,320	5			12,492		10
11	19	Professional Services	Resident Days	93,320	5	10,378		12,492	1,389	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	93,320	5	10,855		12,492	1,453	12
13	21	Clerical and General Office	Resident Days	93,320	5	26,653		12,492	3,568	13
14	22	Employee Benefits & Payroll	Resident Days	93,320	5	1,442		12,492	193	14
15	23	Inservice Training & Education	Resident Days	93,320	5			12,492		15
16	24	Travel and Seminar	Resident Days	93,320	5			12,492		16
17	25	Other Admin. Staff Transport.	Resident Days	93,320	5			12,492		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	93,320	5			12,492		18
19	27	Mgmt. Allocation of Benefits	Resident Days	93,320	5			12,492		19
20	30	Depreciation	Resident Days	93,320	5	17,132		12,492	2,293	20
21	32	Interest	Resident Days	93,320	5	84,878		12,492	11,362	21
22	33	Real Estate Taxes	Resident Days	93,320	5			12,492		22
23	34	Rent-Facility and Grounds	Resident Days	93,320	5			12,492		23
24	35	Rent-Equipment & Vehicles	Resident Days	93,320	5			12,492		24
25	TOTALS					\$ 151,338	\$		\$ 20,258	25

Facility Name & ID Number

Sheldon Health Care Center

0046573

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

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	\$ 259,748	01/05/14	0.0700	\$ 19,210	1						
2												2						
3							Interest Income Offset				(52)	3						
4							Home Office Allocation-PHC				2,769	4						
5							Home Office Allocation-PHE				11,362	5						
	Working Capital																	
6												6						
7												7						
8												8						
9	TOTAL Facility Related				\$5,805.00		\$ 500,000	\$ 259,748			\$ 33,289	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	\$ 259,748			\$ 33,289	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

1. Real Estate Tax accrual used on 2008 report.		\$	8,500	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.)	2008	\$	7,783	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(717)	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	8,000	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. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	277	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7,560	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2004	7,309	8
	2005	7,091	9
	2006	7,211	10
	2007	7,466	11
	2008	7,783	12

Accrual based on prior year tax bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2008	\$	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:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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:** 2008 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 2008 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2008.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2008 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 2009 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.

2008 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) 691-8113

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2008 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 2008.

(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>7,783.00</u>	<u>7,783.00</u>
2. _____	_____	_____	_____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>7,783.00</u>	\$ <u>7,783.00</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 and 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 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

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:

1/1/2009 Ending:

12/31/2009

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:

	1	2	3	4	
A. Land.	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	\$ 100,470	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Remodeling		2004	1,175		30	39	39	211	9
10	Landscaping Improvements		2005	1,375		15	92	92	406	10
11	Living room, lobby, hallway paint and border		2005	3,000		30	100	100	458	11
12	Flooring		2006	899		15	60	60	210	12
13	Roof		2006	2,015		25	81	81	283	13
14	Garage Door		2006	693		15	46	46	161	14
15	Watchmate		2006	6,435		5	1,287	1,287	4,505	15
16	Emergency System		2007	985		10	99	99	247	16
17	Carpet		2007	1,076		7	154	154	385	17
18	Concrete		2008	6,380		25	256	256	384	18
19	Sprinkler Repair		2009	9,018		7	644	644	644	19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27	Land Improvements Booked				346			(346)		27
28	Building Booked				19,700			(19,700)		28
29	Building Improvement Booked				2,022			(2,022)		29
30										30
31										31
32	2009-Home Office Allocation-Land Improvements			411			26	26		32
33	2009-Home Office Allocation-Building Improvements			6,141			147	147		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

Facility Name & ID Number Sheldon Health Care Center

0046573

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

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)	\$	\$		\$	\$	\$	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:

1/1/2009

Ending:

12/31/2009

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	\$ 193,922	\$ 27,408	\$ 27,936	\$ 528	3-10 yrs.	\$ 147,887	71
72	Current Year Purchases	7,197	942	360	(582)	10 yrs.	360	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			4,094	4,094			74
75	TOTALS	\$ 201,119	\$ 28,350	\$ 32,390	\$ 4,040		\$ 148,247	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)	\$ 713,222	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 50,418	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 53,151	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,733	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 256,611	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	\$ 1,970	\$ 11,738	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 52,500	\$ 1,970	\$ 11,738	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								6
7	TOTAL				\$			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: \$ 333

Description: See Attached 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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

* 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 1/1/2009

Period End 12/31/2009

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$	9
Copier	\$	59
Home Office Allocation		265
		<u>333</u>
		<u><u>333</u></u>

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		Contract	Total
		1 Drop-outs	2 Completed		
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	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)							
					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	N/A	hrs													4
5	Physician Care		visits													5
6	Dental Care		visits													6
7	Work Related Program		hrs													7
8	Habilitation		hrs													8
9	Pharmacy		# of prescripts													9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify): _____															12
13	Other (specify): _____															13
14	TOTAL			\$				\$		\$			\$			14

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

Facility Name & ID Number Sheldon Health Care Center

0046573

Report Period Beginning: 1/1/2009

Ending: 12/31/2009

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2009

(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	\$ (480,772)	\$ (480,772)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>N/A</u>)	110,060	110,060	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	15,720	15,720	6
7	Other Prepaid Expenses	5,145	5,145	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Prepaid Mgmt. Fees</u>	20,000	20,000	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (329,847)	\$ (329,847)	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	40,255	29,250	13
14	Buildings, at Historical Cost	492,500	449,391	14
15	Leasehold Improvements, at Historical Cost	25,296	33,462	15
16	Equipment, at Historical Cost	201,119	201,119	16
17	Accumulated Depreciation (book methods)	(275,185)	(256,611)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Apartment Units</u>		52,500	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 483,985	\$ 509,111	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 154,138	\$ 179,264	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 329,901	\$ 329,901	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	34,996	34,996	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,317	1,317	31
32	Accrued Real Estate Taxes(Sch.IX-B)	8,000	8,000	32
33	Accrued Interest Payable	4,470	4,470	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	28,435	28,435	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 407,119	\$ 407,119	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	259,748	259,748	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Security Deposit</u>	2,100	2,100	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 261,848	\$ 261,848	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 668,967	\$ 668,967	46
47	TOTAL EQUITY (page 18, line 24)	\$ (514,829)	\$ (489,703)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 154,138	\$ 179,264	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (634,035)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (634,035)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	119,206	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)	\$ 119,206	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)	\$ (514,829)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Sheldon Health Care Center

0046573

Report Period Beginning: 1/1/2009

Ending: 12/31/2009

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 1,155,904	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,155,904	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	2,220	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)	\$ 2,220	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	52	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 52	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	146	28
28a	Meals on Wheels Revenue	3,098	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,244	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,161,420	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	305,919	31
32	Health Care	423,439	32
33	General Administration	208,457	33
B. Capital Expense			
34	Ownership	76,979	34
C. Ancillary Expense			
35	Special Cost Centers	10,447	35
36	Provider Participation Fee	16,973	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,042,214	40
41	Income before Income Taxes (line 30 minus line 40)**	119,206	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 119,206	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 part of 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:

1/1/2009

Ending:

12/31/2009

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	796	796	\$ 22,196	\$ 27.88	1
2	Assistant Director of Nursing	820	820	20,272	24.72	2
3	Registered Nurses	1,471	1,480	33,096	22.36	3
4	Licensed Practical Nurses	7,508	7,906	150,983	19.10	4
5	CNAs & Orderlies	15,112	15,554	145,628	9.36	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,908	2,108	28,410	13.48	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	23,845	11.46	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,125	6,502	56,597	8.70	15
16	Dishwashers					16
17	Maintenance Workers	1,239	1,271	15,790	12.42	17
18	Housekeepers	6,272	6,310	52,692	8.35	18
19	Laundry	1,024	1,028	8,151	7.93	19
20	Administrator	2,080	2,080	41,811	20.10	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)					33
34	TOTAL (lines 1 - 33)	46,435	47,935	\$ 599,471 *	\$ 12.51	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant			35	
36	Medical Director	Monthly	3,600	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	373	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)		\$ 3,973		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

Sheldon Health Care Center**0046573****Period Beginning 1/1/2009****Period End 12/31/2009****Schedule 21A****XIX. SUPPORT SCHEDULE****C. Professional Services**

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		9,004

Home Office Allocation

Heyl, Royster, Voelker & Allen	Legal	20
GoffWilson, P.A.	Legal	28
Jackson Lewis	Legal	219
Peter Gartelos	Legal	21
Misc.	Legal	19
Ginoli & Company	Accountants	1,876
Miscellaneous Vendors	Computer Services	20
Emdeon Business Services	Computer Services	9
Advanced Answers on Demand	Computer Services	1,177
Access 2 Go	Computer Services	113
Ivans	Computer Services	13
Kemper Technology	Computer Services	320
VisionShare	Computer Services	100
MediFax	Computer Services	41
Logmein	Computer Services	18
Charter Communications	Computer Services	1
Simple LTC	Computer Services	271
Miscellaneous Vendors	Miscellaneous	186
Total (agree to Schedule V, line 19, column 8)		<u>13,456</u>

Facility Name & ID Number Sheldon Health Care Center

0046573

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

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. 1,500 IHCA
- (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? No
- (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. \$ 2,150 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? N/A
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 16,973
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (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? Yes 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. **See attached P 23A**
- (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. \$ 5,318
- (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. \$ No
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? N/A**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (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

**Sheldon Health Care Center
0046573**

Period Beginning 1/1/2009

Period End 12/31/2009

Independent Living Offset

Schedule 23A

Census Days Summary:

	Days	%
Independent Living	2,390	19.13%
Nursing Home	10,101	80.87%
	<u>12,491</u>	<u>100.00%</u>

Expense Offset:	Total Amount	Ind. Liv %	Ind. Liv Offset	Basis For Allocation	Line
Dietary	86,910	19.13%	16,626	Census	1
Food	68,828	19.13%	13,167	Census	2
Housekeeping	61,388	19.13%	11,744	Census	3
Laundry	12,906	19.13%	2,469	Census	4
Utilities	37,162	19.13%	7,109	Census	5
Maintenance	38,725	19.13%	7,408	Census	6
Depreciation (Building)	<u>1,970</u>	100.00%	<u>1,970</u>	S/L Depr	30
Total	<u><u>307,889</u></u>		<u><u>60,493</u></u>		

Note: Computed overhead cost of Independent Living based on census days. Independent Living depreciation expense was calculated based on straight-line depreciation over an estimated useful life of 25 years. Independent Living overhead and depreciation cost have been offset on P5A.