

		FOR BHF USE					

LL1

2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0046805

Facility Name: Tuscola Health Care Center

Address: 1203 Egyptian Trail Tuscola 61953
 Number City Zip Code

County: Douglas

Telephone Number: (217) 253-4791 **Fax #** (217) 253-3754

HFS ID Number: 200349783003

Date of Initial License for Current Owners: 1/18/2005

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input checked="" type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: Christine A. Hanover **Telephone Number:** (312) 634-4581
 Please send copies of desk review and audit adjustments to address on this page.

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/06 to 12/31/06 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed) _____
	(Date) _____
Paid Preparer	(Type or Print Name) _____
	(Title) _____
Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u>
	(Date) _____
	(Print Name and Title) _____
	(Firm Name & Address) <u>McGladrey & Pullen, LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u>
	(Telephone) <u>(312) 384-6000</u> Fax # <u>(312) 634-5518</u>
	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tuscola Health Care Center

0046805 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	21	Skilled (SNF)	21	7,665	1
2		Skilled Pediatric (SNF/PED)			2
3	52	Intermediate (ICF)	52	18,980	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	73	TOTALS	73	26,645	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		2 Medicaid Recipient	3 Private Pay	4 Other		
8	SNF			1,466	1,466	8
9	SNF/PED					9
10	ICF	11,686	6,256		17,942	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,686	6,256	1,466	19,408	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.84%

D. How many bed-hold days during this year were paid by the Department? 0 (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)

Home Care

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 8/01/04

J. Was the facility purchased or leased after January 1, 1978?
 YES Date 1/18/05 NO

K. Was the facility certified for Medicare during the reporting year?
 YES NO If YES, enter number of beds certified 21 and days of care provided 1,466

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tuscola Health Care Center# 0046805

Report Period Beginning:

01/01/06

Ending:

12/31/06**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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	112,170	10,878	1,260	124,308		124,308	1,380	125,688		1
2	Food Purchase		83,535		83,535		83,535	(5,818)	77,717		2
3	Housekeeping	79,475	11,167		90,642		90,642	61	90,703		3
4	Laundry	21,490	8,998		30,488		30,488		30,488		4
5	Heat and Other Utilities			67,965	67,965		67,965	279	68,244		5
6	Maintenance	24,803	18,656	4,642	48,101		48,101	3,509	51,610		6
7	Other (specify):* Home office benefit							553	553		7
8	TOTAL General Services	237,938	133,234	73,867	445,039		445,039	(36)	445,003		8
	B. Health Care and Programs										
9	Medical Director			8,400	8,400		8,400		8,400		9
10	Nursing and Medical Records	721,088	119,780	1,118	841,986		841,986	4,990	846,976		10
10a	Therapy			98,370	98,370		98,370	458	98,828		10a
11	Activities	19,963	1,492	3,455	24,910		24,910	74,297	99,207		11
12	Social Services	22,193			22,193		22,193		22,193		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home office benefit							1,543	1,543		15
16	TOTAL Health Care and Programs	763,244	121,272	111,343	995,859		995,859	81,288	1,077,147		16
	C. General Administration										
17	Administrative	53,422		112,000	165,422		165,422	(98,398)	67,024		17
18	Directors Fees										18
19	Professional Services			9,992	9,992		9,992	8,499	18,491		19
20	Dues, Fees, Subscriptions & Promotions			3,899	3,899		3,899	2,903	6,802		20
21	Clerical & General Office Expenses	31,129	6,820	24,109	62,058		62,058	23,790	85,848		21
22	Employee Benefits & Payroll Taxes			401,040	401,040		401,040	7,191	408,231		22
23	Inservice Training & Education			2,452	2,452		2,452	177	2,629		23
24	Travel and Seminar			39	39		39	5,310	5,349		24
25	Other Admin. Staff Transportation			7,727	7,727		7,727	2,075	9,802		25
26	Insurance-Prop.Liab.Malpractice			19,070	19,070		19,070	1,045	20,115		26
27	Other (specify):* Home office benefit							3,875	3,875		27
28	TOTAL General Administration	84,551	6,820	580,328	671,699		671,699	(43,533)	628,166		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,085,733	261,326	765,538	2,112,597		2,112,597	37,719	2,150,316		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

Facility Name & ID Number Tuscola Health Care Center

#0046805

Report Period Beginning:

01/01/06

Ending:

12/31/06

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			41,606	41,606		41,606	5,583	47,189			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			58,341	58,341		58,341	20,475	78,816			32
33	Real Estate Taxes			34,057	34,057		34,057	633	34,690			33
34	Rent-Facility & Grounds							614	614			34
35	Rent-Equipment & Vehicles			16,883	16,883		16,883	322	17,205			35
36	Other (specify):*											36
37	TOTAL Ownership			150,887	150,887		150,887	27,627	178,514			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			39,968	39,968		39,968		39,968			42
43	Other (specify):* Nonallowable Cost			61,924	61,924		61,924	(61,924)				43
44	TOTAL Special Cost Centers			101,892	101,892		101,892	(61,924)	39,968			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,085,733	261,326	1,018,317	2,365,376		2,365,376	3,422	2,368,798			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.

SEE ACCOUNTANTS' COMPILATION REPORT

See Accountants' Compilation Report

Facility Name & ID Number Tuscola Health Care Center

0046805

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(680)	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	177	30		9
10	Interest and Other Investment Income	(880)	25		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(202)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(13,257)	43		24
25	Fund Raising, Advertising and Promotional	(9,417)	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 page 5A	(41,430)	var		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (65,689)		\$	30

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)	69,111		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 69,111		36
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 3,422		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

BHF USE ONLY							
48		49		50		51	
							52

SEE ACCOUNTANTS' COMPILATION REPORT

Tuscola Health Care Center

ID# 0046805

Report Period Beginning: 01/01/06

Ending: 12/31/06

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Nonallowable marketing expense	\$ (1,005)	1
2	Labs - Part A	(30,029)	2
3	X-Rays - Part A	(1,358)	3
4	Offset Vending Machine Revenue	(518)	4
5	Offset Meal Revenue	(2,236)	5
6	Chamber Dues	(175)	6
7	Offset Misc Revenue	(218)	7
8	Special Events	(1,811)	8
9	Nonallowable home office architect fees	(431)	9
10	Offset Home Health Salary	(3,649)	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	(41,430)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Tuscola Health Care Center

0046805

Report Period Beginning:

01/01/06

Ending:

12/31/06

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	1,380	0	0	0	0	0	0	0	0	0	1,380	1
2	Food Purchase	0	68	0	0	0	0	0	0	0	0	0	68	2
3	Housekeeping	0	61	0	0	0	0	0	0	0	0	0	61	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	256	0	23	0	0	0	0	0	0	0	279	5
6	Maintenance	0	3,510	0	0	0	0	0	0	0	0	0	3,510	6
7	Other (specify):*	0	553	0	0	0	0	0	0	0	0	0	553	7
8	TOTAL General Services	0	5,828	0	23	0	0	0	0	0	0	0	5,851	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	4,990	0	0	0	0	0	0	0	0	0	4,990	10
10a	Therapy	0	458	0	0	0	0	0	0	0	0	0	458	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	1,543	0	0	0	0	0	0	0	0	0	1,543	15
16	TOTAL Health Care and Programs	0	6,991	0	0	0	0	0	0	0	0	0	6,991	16
	C. General Administration													
17	Administrative	0	(98,398)	0	74,297	0	0	0	0	0	0	0	(24,101)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	5,957	0	2,973	0	0	0	0	0	0	0	8,930	19
20	Fees, Subscriptions & Promotions	0	584	0	2,495	0	0	0	0	0	0	0	3,079	20
21	Clerical & General Office Expenses	0	0	21,927	2,080	0	0	0	0	0	0	0	24,007	21
22	Employee Benefits & Payroll Taxes	0	0	0	3,542	0	0	0	0	0	0	0	3,542	22
23	Inservice Training & Education	0	0	177	0	0	0	0	0	0	0	0	177	23
24	Travel and Seminar	0	0	5,309	0	0	0	0	0	0	0	0	5,309	24
25	Other Admin. Staff Transportation	(880)	0	1,412	663	0	0	0	0	0	0	0	1,195	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,045	0	0	0	0	0	0	0	0	1,045	26
27	Other (specify):*	0	0	3,875	0	0	0	0	0	0	0	0	3,875	27
28	TOTAL General Administration	(880)	(91,857)	33,745	86,050	0	0	0	0	0	0	0	27,058	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(880)	(79,038)	33,745	86,073	0	0	0	0	0	0	0	39,900	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Tuscola Health Care Center # 0046805 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	177	0	5,406	0	0	0	0	0	0	0	0	5,583	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	3,003	18,352	0	0	0	0	0	0	0	21,355	32
33	Real Estate Taxes	0	0	634	0	0	0	0	0	0	0	0	634	33
34	Rent-Facility & Grounds	0	0	614	0	0	0	0	0	0	0	0	614	34
35	Rent-Equipment & Vehicles	0	0	322	0	0	0	0	0	0	0	0	322	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	177	0	9,979	18,352	0	0	0	0	0	0	0	28,508	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):*	(23,556)	0	0	0	0	0	0	0	0	0	0	(23,556)	43
44	TOTAL Special Cost Centers	(23,556)	0	0	0	0	0	0	0	0	0	0	(23,556)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(24,259)	(79,038)	43,724	104,425	0	0	0	0	0	0	0	44,852	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		See Attached Schedule 6A		See Attached Schedule 6A		

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 1,380	\$ 1,380	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	68	68	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	61	61	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	256	256	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	3,510	3,510	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	553	553	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	4,990	4,990	8
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	458	458	9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,543	1,543	10
11	V	17 Administrative	112,000	Petersen Health Care, Inc.	100.00%	13,602	(98,398)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	5,957	5,957	12
13	V	20 Due, Fees, Subs & Promos		Petersen Health Care, Inc.	100.00%	584	584	13
14	Total		\$ 112,000			\$ 32,962	\$ * (79,038)	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tuscola Health Care Center # 0046805 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	21 Clerical & General Office	\$	Petersen Health Care, Inc.	100.00%	\$ 21,927	\$	21,927	15
16	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	177		177	16
17	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	5,309		5,309	17
18	V	25 Other Admin. Staff Transport		Petersen Health Care, Inc.	100.00%	1,412		1,412	18
19	V	26 Insurance-Prop.Liab.Malpractice		Petersen Health Care, Inc.	100.00%	1,045		1,045	19
20	V	27 Mgmt Allocation of Benefits		Petersen Health Care, Inc.	100.00%	3,875		3,875	20
21	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	5,406		5,406	21
22	V	32 Interest		Petersen Health Care, Inc.	100.00%	3,003		3,003	22
23	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	634		634	23
24	V	34 Rent - Facility & Grounds		Petersen Health Care, Inc.	100.00%	614		614	24
25	V	35 Rent - Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	322		322	25
26	V								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		\$			\$ 43,724	\$ *	43,724	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tuscola Health Care Center

0046805

Report Period Beginning: 01/01/06

Ending: 12/31/06

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	5 Utilities	\$	Petersen Health Enterprises	0.00%	\$ 23	\$	23	15
16	V	17 Administrative		Petersen Health Enterprises	0.00%	74,297		74,297	16
17	V	19 Professional Services		Petersen Health Enterprises	0.00%	2,973		2,973	17
18	V	20 Dues, Fees, Subs & Promotions		Petersen Health Enterprises	0.00%	2,495		2,495	18
19	V	21 Clerical & General Office		Petersen Health Enterprises	0.00%	2,080		2,080	19
20	V	22 Employee Benefits		Petersen Health Enterprises	0.00%	3,542		3,542	20
21	V	25 Other Admin. Staff Transport		Petersen Health Enterprises	0.00%	663		663	21
22	V	32 Interest		Petersen Health Enterprises	0.00%	18,352		18,352	22
23	V								23
24	V								24
25	V								25
26	V								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		\$			\$ 104,425	\$ *	104,425	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tuscola Health Care Center # 0046805 Report Period Beginning: 01/01/06 Ending: 12/31/06

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Petersen	President	Administrative	70.00	See Schedule 7A	0.85	1.70	Salary	\$ 13,602	L17,C7	1
2	Jifi C. Jacob	Owner	Administrative	10.00	See Schedule 7B	13	26.52	Salary	21,748	L17,C7	2
3	Cindy S. White	Owner	Administrative	10.00	See Schedule 7B	13	26.52	Salary	25,085	L17,C7	3
4	Jacque Whitley	Owner	Administrative	10.00	See Schedule 7B	13	26.52	Salary	27,461	L17,C7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 87,896		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tuscola Health Care Center

0046805

Report Period Beginning:

01/01/06

Ending: 12/31/06

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 West 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	Patient Days	1,141,463	56	\$ 81,179	\$ 19,408	\$ 1,380	1
2	2	Food	Patient Days	1,141,463	56	3,989	19,408	68	2
3	3	Housekeeping	Patient Days	1,141,463	56	3,589	19,408	61	3
4	4	Laundry	Patient Days	1,141,463	56	0	19,408	0	4
5	5	Utilities	Patient Days	1,141,463	56	15,054	19,408	256	5
6	6	Maintenance	Patient Days	1,141,463	56	206,416	110,513	3,510	6
7	7	Mgmt. Allocation of Benefits	Patient Days	1,141,463	56	32,526	19,408	553	7
8	10	Nursing and Medical Records	Patient Days	1,141,463	56	293,462	289,197	4,990	8
9	10A	Therapy	Patient Days	1,141,463	56	26,945	19,408	458	9
10	15	Mgmt. Allocation of Benefits	Patient Days	1,141,463	56	90,724	19,408	1,543	10
11	17	Administrative	Patient Days	1,141,463	56	800,000	800,000	13,602	11
12	19	Professional Services	Patient Days	1,141,463	56	350,361	19,408	5,957	12
13	20	Due, Fees, Subs & Promos	Patient Days	1,141,463	56	34,325	19,408	584	13
14	21	Clerical & General Office	Patient Days	1,141,463	56	1,289,623	954,322	21,927	14
15	23	Inservice Training & Education	Patient Days	1,141,463	56	10,426	19,408	177	15
16	24	Travel and Seminar	Patient Days	1,141,463	56	312,259	19,408	5,309	16
17	25	Other Admin. Staff Transport	Patient Days	1,141,463	56	83,062	19,408	1,412	17
18	26	Insurance-Prop.Liab.Malpractice	Patient Days	1,141,463	56	61,457	19,408	1,045	18
19	27	Mgmt Allocation of Benefits	Patient Days	1,141,463	56	227,912	19,408	3,875	19
20	30	Depreciation	Patient Days	1,141,463	56	317,964	19,408	5,406	20
21	32	Interest	Patient Days	1,141,463	56	176,614	19,408	3,003	21
22	33	Real Estate Taxes	Patient Days	1,141,463	56	37,282	19,408	634	22
23	34	Rent - Facility & Grounds	Patient Days	1,141,463	56	36,133	19,408	614	23
24	35	Rent - Equipment & Vehicles	Patient Days	1,141,463	56	18,933	19,408	322	24
25	TOTALS					\$ 4,510,235	\$ 2,234,999	\$ 76,686	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tuscola Health Care Center

0046805

Report Period Beginning:

01/01/06

Ending: 12/31/06

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 Enterprises
 Street Address 830 West 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	5	Utilities	Patient Days	73,177	5	\$ 85	19,408	\$ 23	1
2	17	Administrative	Patient Days	73,177	5	280,132	19,408	74,297	2
3	19	Professional Services	Patient Days	73,177	5	11,209	19,408	2,973	3
4	20	Dues, Fees, Subs & Promos	Patient Days	73,177	5	9,408	19,408	2,495	4
5	21	Clerical & General Office	Patient Days	73,177	5	7,841	19,408	2,080	5
6	22	Employee Benefits	Patient Days	73,177	5	13,355	19,408	3,542	6
7	25	Other Admin. Staff Transport	Patient Days	73,177	5	2,500	19,408	663	7
8	32	Interest	Patient Days	73,177	5	69,197	19,408	18,352	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	TOTALS					\$ 393,727	\$ 280,132	\$ 104,425	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tuscola Health Care Center # 0046805 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	F & M Bank of Galesburg, IL		X	Mortgage	\$5,744.00	5/6/2005	\$ 708,120	\$ 681,970	5/6/2008	0.0748	\$ 53,378	1								
2	F & M Bank of Galesburg, IL		X	Purchase Van	\$566.00	9/30/2005	28,696	22,417	9/30/2010	0.0675	1,728	2								
3							Home Office Allocation				21,356	3								
4							Amortization of mortgage costs				3,234	4								
5							Interest Income Offset				(880)	5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related				\$6,310.00		\$ 736,816	\$ 704,387			\$ 78,816	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 736,816	\$ 704,387			\$ 78,816	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.) SEE ACCOUNTANTS' COMPILATION REPORT

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 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 2006 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.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Tuscola Health Care Center COUNTY Douglas

FACILITY IDPH LICENSE NUMBER 0046805

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 2005 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 2005.

(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>09-08-02-100-027</u>	<u>Nursing Home</u>	\$ <u>15,124.78</u>	\$ <u>15,124.78</u>
2. <u>09-08-02-100-029</u>	<u>Nursing Home</u>	\$ <u>13,066.22</u>	\$ <u>13,066.22</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>28,191.00</u>	\$ <u>28,191.00</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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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 Tuscola Health Care Center# 0046805

Report Period Beginning:

01/01/06

Ending:

12/31/06**X. BUILDING AND GENERAL INFORMATION:**A. Square Feet: 21,274 B. General Construction Type: Exterior Brick & Masonry Frame Steel Number of Stories 1C. 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/AF. 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: N/A 2. Number of Years Over Which it is Being Amortized: N/A3. Current Period Amortization: N/A 4. Dates Incurred: N/A

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>Resident Care</u>	<u>187,955</u>	<u>2005</u>	<u>\$ 50,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	187,955		\$ 50,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tuscola Health Care Center

0046805

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	73	2005	1974	\$ 500,000	\$	30	\$ 16,667	\$ 16,667	\$ 33,335	4
5										5
6	Allocation		2006	11,576			506	506	506	6
7	From Home									7
8	Office									8
Improvement Type**										
9	Carpeting		2005	1,286		25	51	51	94	9
10	Tiles		2005	2,945		10	295	295	540	10
11	Sidewalks		2005	3,900		15	260	260	390	11
12	Fire Alarm System		2006	4,552		5	455	455	455	12
13										13
14										14
15										15
16										16
17	Land Improvement Booked				260			(260)		17
18	Building Booked				16,667			(16,667)		18
19	Building Improvement Booked				498			(498)		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	2006 Allocation from Home Office - Land Improvements		2006	669			62	62	62	34
35	2006 Allocation from Home Office Buildings - Improvements		2006	19			1	1	1	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tuscola Health Care Center

0046805

Report Period Beginning:

01/01/06

Ending:

12/31/06

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)	\$	524,947	\$	17,424	\$	18,297	\$	873	\$	35,383	70

SEE ACCOUNTANTS' COMPILATION REPORT

**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	\$ 162,200	\$ 18,443	\$ 17,008	\$ (1,435)	5-10	\$ 33,384	71
72	Current Year Purchases	16,333		1,308	1,308	5-10	1,308	72
73	Fully Depreciated Assets							73
74	Allocation from Home Office			4,837	4,837			74
75	TOTALS	\$ 178,533	\$ 18,443	\$ 23,153	\$ 4,710		\$ 34,692	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	Patient Care	'06 Ford Econoline	2005	\$ 28,696	\$ 5,739	\$ 5,739		5	\$ 7,174	76
77										77
78										78
79										79
80	TOTALS			\$ 28,696	\$ 5,739	\$ 5,739			\$ 7,174	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)	\$ 782,176	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 41,606	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 47,189	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 5,583	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 77,249	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.

SEE ACCOUNTANTS' COMPILATION REPORT

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	Other (Home Office Allocation)			614			5
6							6
7	TOTAL			\$ 614			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

N/A

N/A

N/A

9. Option to Buy:

YES

NO

Terms: N/A

*

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: \$ 17,205

Description:

Copier \$3,433, Dishwasher \$150, Maint. Equip \$29, Home Ofc. \$322, Laundry \$30, Nursing Equip \$13,241

(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	<u>N/A</u>		\$	\$	17
18					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. /2007 \$ _____

13. /2008 \$ _____

14. /2009 \$ _____

* 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.

SEE ACCOUNTANTS' COMPILATION REPORT

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.
- SEE ACCOUNTANTS' COMPILATION REPORT**

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	\$	640	\$ 51,050	\$	640	\$ 51,050	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		28	2,430		28	2,430	2
3	Licensed Recreational Therapist	10A(3)	hrs		580	44,890		580	44,890	3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							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			\$	1,248	\$ 98,370	\$	1,248	\$ 98,370	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.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Tuscola Health Care Center

0046805

Report Period Beginning: 01/01/06

Ending:

12/31/06

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/06

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 476,372	\$ 476,372	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>-0</u>)	257,058	257,058	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	6,232	6,232	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Employee Advances</u>	2,700	2,700	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 742,362	\$ 742,362	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	53,900	50,000	13
14	Buildings, at Historical Cost	8,784	13,372	14
15	Leasehold Improvements, at Historical Cost	500,000	511,575	15
16	Equipment, at Historical Cost	207,229	207,229	16
17	Accumulated Depreciation (book methods)	(77,957)	(77,249)	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>Loan Costs</u>	24,522	24,522	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 716,478	\$ 729,449	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,458,840	\$ 1,471,811	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 251,824	\$ 251,824	26
27	Officer's Accounts Payable	399,459	399,459	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	80,997	80,997	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,601	1,601	31
32	Accrued Real Estate Taxes(Sch.IX-B)	28,191	28,191	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Withholdings</u>	16,136	16,136	36
37	<u>Other Accrued Exp</u>	31,324	31,324	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 809,532	\$ 809,532	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	22,417	22,417	39
40	Mortgage Payable	681,970	681,970	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 704,387	\$ 704,387	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,513,919	\$ 1,513,919	46
47	TOTAL EQUITY(page 18, line 24)	\$ (55,079)	\$ (42,108)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,458,840	\$ 1,471,811	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 134,860	1
2	Restatements (describe):		2
3	Post Cost Report Audit Adjustments	(385)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 134,475	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(189,552)	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) rounding	(2)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (189,554)	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)	\$ (55,079)	24 *

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 1,847,335	1
2	Discounts and Allowances for all Levels	18,502	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,865,837	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	184,532	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 184,532	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants	23,038	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	100	13
14	Non-Patient Meals	2,236	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	80,424	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	10,825	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 116,623	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	880	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 880	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending	519	28
28a	Misc Rev \$218 - Home Care Rev \$7,215	7,433	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 7,952	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,175,824	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	445,039	31
32	Health Care	995,859	32
33	General Administration	671,699	33
B. Capital Expense			
34	Ownership	150,887	34
C. Ancillary Expense			
35	Special Cost Centers	61,924	35
36	Provider Participation Fee	39,968	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,365,376	40
41	Income before Income Taxes (line 30 minus line 40)**	(189,552)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (189,552)	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.

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

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

Facility Name & ID Number **Tuscola Health Care Center**

0046805

Report Period Beginning: **01/01/06**

Ending:

12/31/06

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,647	1,647	\$ 45,185	\$ 27.44	1
2	Assistant Director of Nursing		0			2
3	Registered Nurses	7,778	8,364	178,361	21.32	3
4	Licensed Practical Nurses	6,799	7,239	127,785	17.65	4
5	CNAs & Orderlies	26,156	27,654	325,202	11.76	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,025	1,025	8,149	7.95	9
10	Activity Assistants	2,560	2,560	6,503	2.54	10
11	Social Service Workers	2,884	3,017	22,193	7.36	11
12	Dietician					12
13	Food Service Supervisor	1,907	1,907	24,816	13.01	13
14	Head Cook			0		14
15	Cook Helpers/Assistants	10,448	10,712	87,354	8.15	15
16	Dishwashers					16
17	Maintenance Workers	2,080	2,080	24,803	11.92	17
18	Housekeepers	7,617	8,082	79,475	9.83	18
19	Laundry	2,031	2,164	21,490	9.93	19
20	Administrator	2,207	2,255	53,422	23.69	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,894	2,054	31,129	15.15	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 Care Plan Coord	2,056	2,160	44,556	20.63	32
33	Other(specify) <u>Transportation</u>	678	703	5,311	7.55	33
34	TOTAL (lines 1 - 33)	79,766	83,622	\$ 1,085,733 *	\$ 12.98	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	24	\$ 1,260	1,3	35
36	Medical Director	Monthly	8,400	9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,073	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) <u>Rehab</u>	2	45	10,3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	26	\$ 10,778		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3	N/A											
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tuscola Health Care Center

0046805

Report Period Beginning: 01/01/06

Ending: 12/31/06

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5-10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 26,510 Line 10,2
- (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. \$ 39,968
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. \$ 3,649 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,236
- (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? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, 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.

SEE ACCOUNTANTS' COMPILATION REPORT