



Facility Name & ID Number Arcola Health Care Center

# 0046045 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds \_\_\_\_\_

	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	50	Skilled (SNF)	50	18,250	1
2		Skilled Pediatric (SNF/PED)			2
3	50	Intermediate (ICF)	50	18,250	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	100	TOTALS	100	36,500	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			1,240	1,240	8
9	SNF/PED					9
10	ICF	27,991	3,484	1,024	32,499	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,991	3,484	2,264	33,739	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.44%

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

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

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

None

F. Does the facility maintain a daily midnight census?

Yes

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

YES

NO

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

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

YES

NO

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

Date started 11/9/1993

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

YES

Date 11/09/1993

NO

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

YES

NO

If YES, enter number of beds certified 50 and days of care provided 1,240

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL

MODIFIED

CASH\*

CASH\*

Is your fiscal year identical to your tax year?

YES  NO

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

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

Facility Name & ID Number Arcola Health Care Center # 0046045 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	134,266	15,585	840	150,691		2,823	153,514		1	
2	Food Purchase		148,185		148,185		(4,593)	143,592		2	
3	Housekeeping	88,598	21,754		110,352		32	110,384		3	
4	Laundry	44,996	9,811		54,807		2	54,809		4	
5	Heat and Other Utilities			117,194	117,194		482	117,676		5	
6	Maintenance	36,024	6,179	25,473	67,676		3,933	71,609		6	
7	Other (specify):* Home Off. Ben. All.						1,288	1,288		7	
8	<b>TOTAL General Services</b>	303,884	201,514	143,507	648,905		3,967	652,872		8	
	<b>B. Health Care and Programs</b>										
9	Medical Director			32,400	32,400			32,400		9	
10	Nursing and Medical Records	806,469	58,086	54,839	919,394		7,465	926,859		10	
10a	Therapy		33	70,039	70,072			70,072		10a	
11	Activities	57,203	477	360	58,040			58,040		11	
12	Social Services	20,452			20,452			20,452		12	
13	CNA Training									13	
14	Program Transportation									14	
15	Other (specify):* Home Off. Ben. All.						1,660	1,660		15	
16	<b>TOTAL Health Care and Programs</b>	884,124	58,596	157,638	1,100,358		9,125	1,109,483		16	
	<b>C. General Administration</b>										
17	Administrative	41,311			41,311		21,017	62,328		17	
18	Directors Fees									18	
19	Professional Services			8,309	8,309		5,705	14,014		19	
20	Dues, Fees, Subscriptions & Promotions			10,196	10,196		1,236	11,432		20	
21	Clerical & General Office Expenses	20,353	5,702	8,572	34,627		47,669	82,296		21	
22	Employee Benefits & Payroll Taxes			195,511	195,511			195,511		22	
23	Inservice Training & Education						550	550		23	
24	Travel and Seminar						876	876		24	
25	Other Admin. Staff Transportation			5,778	5,778		3,174	8,952		25	
26	Insurance-Prop.Liab.Malpractice			22,332	22,332		1,292	23,624		26	
27	Other (specify):* Home Off. Ben. All.						13,684	13,684		27	
28	<b>TOTAL General Administration</b>	61,664	5,702	250,698	318,064		95,203	413,267		28	
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,249,672	265,812	551,843	2,067,327		2,067,327	108,295	2,175,622	29	

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

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

Facility Name &amp; ID Number

Arcola Health Care Center

#0046045

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			45,927	45,927		45,927	15,203	61,130			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			236,631	236,631		236,631	5,825	242,456			32
33	Real Estate Taxes			32,944	32,944		32,944	(3,776)	29,168			33
34	Rent-Facility & Grounds							68	68			34
35	Rent-Equipment & Vehicles			14,318	14,318		14,318	889	15,207			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			329,820	329,820		329,820	18,209	348,029			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		53,301		53,301		53,301		53,301			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,750	54,750		54,750		54,750			42
43	Other (specify):* Non-allowable Cost		120	47,164	47,284		47,284	(47,164)	120			43
44	<b>TOTAL Special Cost Centers</b>		53,421	101,914	155,335		155,335	(47,164)	108,171			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,249,672	319,233	983,577	2,552,482		2,552,482	79,340	2,631,822			45

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

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

**VI. ADJUSTMENT DETAIL**

**A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,294)	2		4
5	Telephone, TV & Radio in Resident Rooms	(7,380)	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	11,852	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(539)	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)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(19,700)	43		24
25	Fund Raising, Advertising and Promotional	(3,902)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg. 5A	(22,088)	Various		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (45,071)		\$	30

BHF USE ONLY					
48		49		50	
				51	
					52

**B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)**

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	124,411	Various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 124,411		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 79,340		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

**C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)**

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		x	\$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

Arcola Health Care Center

ID# 0046045

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (2,799)	43	1
2	X-Rays-Part A	540	43	2
3	Disallow Real Estate Taxes on Non-Care Property	(4,880)	33	3
4	Offset Vending Revenue	(14,761)	2	4
5	Offset Miscellaneous Office Supplies Revenue	(188)	21	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(22,088)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Arcola Health Care Center# 0046045

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	2,823	0	0	0	0	0	0	0	0	0	2,823	1
2	Food Purchase	(18,055)	98	0	0	0	0	0	0	0	0	0	(17,957)	2
3	Housekeeping	0	32	0	0	0	0	0	0	0	0	0	32	3
4	Laundry	0	2	0	0	0	0	0	0	0	0	0	2	4
5	Heat and Other Utilities	0	482	0	0	0	0	0	0	0	0	0	482	5
6	Maintenance	0	3,933	0	0	0	0	0	0	0	0	0	3,933	6
7	Other (specify):*	0	1,288	0	0	0	0	0	0	0	0	0	1,288	7
8	<b>TOTAL General Services</b>	<b>(18,055)</b>	<b>8,658</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(9,397)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	7,465	0	0	0	0	0	0	0	0	0	7,465	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	1,660	0	0	0	0	0	0	0	0	0	1,660	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>9,125</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>9,125</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	21,017	0	0	0	0	0	0	0	0	0	21,017	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	5,705	0	0	0	0	0	0	0	0	0	5,705	19
20	Fees, Subscriptions & Promotions	0	0	1,236	0	0	0	0	0	0	0	0	1,236	20
21	Clerical & General Office Expenses	(188)	0	47,857	0	0	0	0	0	0	0	0	47,669	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	550	0	0	0	0	0	0	0	0	550	23
24	Travel and Seminar	0	0	876	0	0	0	0	0	0	0	0	876	24
25	Other Admin. Staff Transportation	0	0	3,174	0	0	0	0	0	0	0	0	3,174	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,292	0	0	0	0	0	0	0	0	1,292	26
27	Other (specify):*	0	0	13,684	0	0	0	0	0	0	0	0	13,684	27
28	<b>TOTAL General Administration</b>	<b>(188)</b>	<b>26,722</b>	<b>68,669</b>	<b>0</b>	<b>95,203</b>	<b>28</b>							
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(18,243)</b>	<b>44,505</b>	<b>68,669</b>	<b>0</b>	<b>94,931</b>	<b>29</b>							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Arcola Health Care Center # 0046045 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	11,852	0	3,351	0	0	0	0	0	0	0	0	15,203	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	5,825	0	0	0	0	0	0	0	0	5,825	32
33	Real Estate Taxes	(4,880)	0	1,104	0	0	0	0	0	0	0	0	(3,776)	33
34	Rent-Facility & Grounds	0	0	68	0	0	0	0	0	0	0	0	68	34
35	Rent-Equipment & Vehicles	0	0	889	0	0	0	0	0	0	0	0	889	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>6,972</b>	<b>0</b>	<b>11,237</b>	<b>0</b>	<b>18,209</b>	<b>37</b>							
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(33,800)	0	0	0	0	0	0	0	0	0	0	(33,800)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(33,800)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(33,800)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(45,071)</b>	<b>44,505</b>	<b>79,906</b>	<b>0</b>	<b>79,340</b>	<b>45</b>							

Facility Name & ID Number

Arcola Health Care Center

# 0046045

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark Petersen	100	See Attached Schedule 6E		See Attached Sch 6E		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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%	\$ 2,823	\$ 2,823	1	
2	V	2 Food		Petersen Health Care, Inc.	100.00%	98	98	2	
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	32	32	3	
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	2	2	4	
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	482	482	5	
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	3,933	3,933	6	
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,288	1,288	7	
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	7,465	7,465	8	
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	0		9	
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,660	1,660	10	
11	V	17 Administrative		Petersen Health Care, Inc.	100.00%	21,017	21,017	11	
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	5,705	5,705	12	
13	V							13	
14	Total		\$			\$ 44,505	\$ *	44,505	14

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	20 Dues, Fees, Subs and Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 1,236	\$	1,236	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	47,857		47,857	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	550		550	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	876		876	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	3,174		3,174	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	1,292		1,292	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	13,684		13,684	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	3,351		3,351	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	5,825		5,825	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	1,104		1,104	24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	68		68	25
26	V	35 Rent-Equipment and Vehicles		Petersen Health Care, Inc.	100.00%	889		889	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	<b>Total</b>		\$			\$ 79,906	\$ *	79,906	39

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

Facility Name &amp; ID Number

Arcola Health Care Center

# 0046045

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Petersen	President	Administrative	100.00	See Schedule 7A	1.38	2.51	Salary	\$ 21,017	L17, C7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 21,017		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    Arcola Health Care Center#    0046045    Report Period Beginning:    01/01/2007    Ending:    2/31/2007

## VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization    Petersen Health Care, 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	1,316,550	66	\$ 110,171	\$ 109,587	33,739	\$ 2,823	1
2	2	Food	Resident Days	1,316,550	66	3,806	0	33,739	98	2
3	3	Housekeeping	Resident Days	1,316,550	66	1,250	0	33,739	32	3
4	4	Laundry	Resident Days	1,316,550	66	73	0	33,739	2	4
5	5	Utilities	Resident Days	1,316,550	66	18,812	0	33,739	482	5
6	6	Maintenance	Resident Days	1,316,550	66	153,468	113,063	33,739	3,933	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	50,271	0	33,739	1,288	7
8	10	Nursing and Medical Records	Resident Days	1,316,550	66	291,305	286,855	33,739	7,465	8
9	10A	Therapy	Resident Days	1,316,550	66	0	0	33,739	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	64,765	0	33,739	1,660	10
11	17	Administrative	Resident Days	1,316,550	66	820,116	820,116	33,739	21,017	11
12	19	Professional Services	Resident Days	1,316,550	66	222,628	0	33,739	5,705	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,316,550	66	48,243	0	33,739	1,236	13
14	21	Clerical and General Office	Resident Days	1,316,550	66	1,867,440	1,544,801	33,739	47,857	14
15	23	Inservice Training & Education	Resident Days	1,316,550	66	21,481	0	33,739	550	15
16	24	Travel and Seminar	Resident Days	1,316,550	66	34,177	0	33,739	876	16
17	25	Other Admin. Staff Transport.	Resident Days	1,316,550	66	123,847	0	33,739	3,174	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,316,550	66	50,427	0	33,739	1,292	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	533,953	0	33,739	13,684	19
20	30	Depreciation	Resident Days	1,316,550	66	130,767	0	33,739	3,351	20
21	32	Interest	Resident Days	1,316,550	66	227,295	0	33,739	5,825	21
22	33	Real Estate Taxes	Resident Days	1,316,550	66	43,090	0	33,739	1,104	22
23	34	Rent-Facility and Grounds	Resident Days	1,316,550	66	2,648	0	33,739	68	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,316,550	66	34,690	0	33,739	889	24
25	TOTALS					\$ 4,854,723	\$ 2,874,422		\$ 124,411	25

Facility Name & ID Number

Arcola Health Care Center

# 0046045

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					Monthly Payment Required	Date of Note				Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO									Original	Balance			
<b>A. Directly Facility Related</b>																
<b>Long-Term</b>																
1	LaSalle Bank		X	Mortgage	\$3,244 + int.	1/17/07	\$ 2,775,000	\$ 2,743,458	12/31/13	Varies	\$ 235,629					
2	Ford Credit		X	Van Purchase	\$639.08	11/22/04	33,217	13,300	11/17/09	0.0590	1,002					
3																
4							Home Office Allocation				5,825					
5																
<b>Working Capital</b>																
6																
7																
8																
9	<b>TOTAL Facility Related</b>				\$639.08		\$ 2,808,217	\$ 2,756,758			\$ 242,456					
<b>B. Non-Facility Related*</b>																
10																
11																
12																
13																
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$					
15	<b>TOTALS (line 9+line14)</b>						\$ 2,808,217	\$ 2,756,758			\$ 242,456					

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.)



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2007 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2006 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Arcola Health Care Center COUNTY Douglas

FACILITY IDPH LICENSE NUMBER 0046045

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

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

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2006 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2006.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>01-14-09-200-00580</u>	<u>Long-Term Care Facility</u>	\$ <u>25,731.92</u>	\$ <u>25,731.92</u>
2. <u>01-14-09-200-005</u>	<u>Long-Term Care Facility</u>	\$ <u>332.30</u>	\$ <u>332.30</u>
3. <u>01-14-09-224-003</u>	<u>Home used by Administrator</u>	\$ <u>4,879.75</u>	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>30,943.97</u>	\$ <u>26,064.22</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? X YES        NO

**NON-CARE PROPERTY WAS DISALLOWED ON P 10**

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

**C. Tax Bills**

Attach a copy of the original 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

**PLEASE NOTE:** Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Arcola Health Care Center

# 0046045

Report Period Beginning:

01/01/2007 Ending:

12/31/2007

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 22,000 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

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

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

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

N/A

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

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

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

**XI. OWNERSHIP COSTS:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>Not Available</u>	<u>1993</u>	<u>\$ 44,078</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>			<b>\$ 44,078</b>	<b>3</b>

Facility Name &amp; ID Number Arcola Health Care Center

# 0046045

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

**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	100	1995	1975	\$ 859,153	\$	35	\$ 24,547	\$ 24,547	\$ 306,837	4
5										5
6										6
7	Home Office Allocation			18,810			459	459		7
8										8
	<b>Improvement Type**</b>									
9	Building Improvement		1993	13,499		20	675	675	9,787	9
10	Building Improvement		1994	31,000		20	1,550	1,550	20,875	10
11	Building Improvement		1995	10,602		20	530	530	6,870	11
12	Landscaping		1997	5,593		20	280	280	2,939	12
13	Parking Lot		1997	6,500		20	325	325	3,413	13
14	Carpeting		1997	934		20	47	47	492	14
15	Door Closer		1997	1,225		20	61	61	642	15
16	Driveway Grading		1998	784		15	52	52	495	16
17	Guttering		1998	1,273		15	85	85	807	17
18	Wiring		1998	6,426		20	321	321	3,051	18
19	Windows		1998	2,330		15	155	155	1,474	19
20	Siding		1998	12,606		20	630	630	5,986	20
21	Doors		1998	765		15	51	51	485	21
22	Sink		1998	901		20	45	45	630	22
23	Garage		1998	8,286		15	552	552	5,245	23
24	Wood Flooring		1999	1,174		20	59	59	500	24
25	Asphalt Lot		1999	4,680		20	234	234	1,989	25
26	Tile		1999	6,477		20	324	324	2,752	26
27	Vinyl Siding		1999	5,600		25	224	224	1,904	27
28	Door Alarms		2000	1,593		20	80	80	599	28
29	Water Heater		2000	5,075		20	254	254	1,905	29
30	Sidewalk		2000	876		20	44	44	330	30
31	Carpeting		2000	670		20	34	34	254	31
32	Scarf Swags/Valances		2001	6,043		20	302	302	1,812	32
33	Scarf Holders		2001	1,083		20	54	54	324	33
34	Fence		2001	2,000		20	100	100	600	34
35	Replacement Wall		2001	686		20	34	34	205	35
36										36

\*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

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

Facility Name &amp; ID Number Arcola Health Care Center

# 0046045

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

## 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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Security System	2002	\$ 5,959	\$	20	\$ 298	\$ 298	\$ 1,639	37
38	Sprinkler System	2002	4,946		20	247	247	1,361	38
39	Sign	2002	1,248		20	62	62	730	39
40	Medicare Wing Expansion	2003	100,808		20	5,040	5,040	22,681	40
41	Architect Fees	2003	1,343		20	67	67	335	41
42	Patio	2003	5,858		20	293	293	1,465	42
43	Medicare Wing Expansion	2003	2,500		20	125	125	563	43
44	Medicare Wing Expansion	2003	750		20	38	38	169	44
45	Medicare Wing Expansion	2003	1,500		20	75	75	338	45
46	Medicare Wing Expansion	2003	500		20	25	25	113	46
47	Furnace	2004	2,195		20	110	110	385	47
48	Roofing	2005	2,500		20	125	125	314	48
49	Asphalt West Lot	2006	21,480		20	1,074	1,074	1,611	49
50	Door Alarm	2007	2,117		10	106	106	106	50
51	Furnace/Air Conditioner	2007	3,985		10	199	199	199	51
52	Blinds	2007	4,431		10	222	222	222	52
53	Windows	2007	19,021		20	476	476	476	53
54									54
55									55
56									56
57	Land Improvement Depreciation per Books			1,871			(1,871)		57
58	Building Depreciation per Books			24,728			(24,728)		58
59	Building Improvement Depreciation per Books			6,322			(6,322)		59
60									60
61									61
62									62
63									63
64									64
65									65
66	2007-Home Office Allocation-Land Improvements		1,259			75	75		66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,199,044	\$ 32,921		\$ 40,765	\$ 7,844	\$ 415,909	70

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

Facility Name & ID Number Arcola Health Care Center

# 0046045

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 101,356	\$ 6,277	\$ 10,136	\$ 3,859	10	\$ 67,205	71
72	Current Year Purchases	15,374	1,127	769	(358)		769	72
73	Fully Depreciated Assets	128,973					128,973	73
74	Home Office Allocation			2,817	2,817			74
75	TOTALS	\$ 245,703	\$ 7,404	\$ 13,722	\$ 6,318		\$ 196,947	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	1994 Dodge Van	1998	\$ 28,010	\$ 1,775	\$	\$ (1,775)	5	\$ 28,010	76
77	Facility	2005 Ford	2004	33,217	3,827	6,643	2,816	5	23,252	77
78										78
79										79
80	TOTALS			\$ 61,227	\$ 5,602	\$ 6,643	\$ 1,041		\$ 51,262	80

E. Summary of Care-Related Assets

	1	Reference	2	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)		\$ 1,550,052	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 45,927	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 61,130	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ 15,203	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 664,118	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	Vending Machine - 1995	\$ 3,856	\$	\$ 3,856	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 3,856	\$	\$ 3,856	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?  YES  NO

If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6		<u>Home Office Allocation</u>			<u>68</u>			6
7	TOTAL				\$ <u>68</u>			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?  YES  NO

16. Rental Amount for movable equipment: \$ 15,207 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			\$ <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. \_\_\_\_\_ /2008 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2009 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2010 \$ \_\_\_\_\_

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

Arcola Health Care Center  
0046045

Period Beginning 01/01/2007  
Period End 12/31/2007

**Schedule 14A**

**XII. Rental Costs**

**B. Equipment**

**16. Description of rental amount for movable equipment**

Copier	2,815
Water Softener	574
Dishwasher	240
Medical Equipment	10,689
Home Office Allocation	889
	<hr/>
	15,207
	<hr/> <hr/>

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L10A, C3	hrs	\$	1,636	\$ 24,539	\$	1,636	\$ 24,539	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		682	10,236		682	10,236	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C2&3	hrs		2,351	35,264	33	2,351	35,297	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescripts				53,301		53,301	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	<b>TOTAL</b>			\$	4,669	\$ 70,039	\$ 53,334	4,669	\$ 123,373	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 Arcola Health Care Center

# 0046045

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 622,513	\$ 622,513	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>None</u> )	514,902	514,902	3
4	Supply Inventory (priced at <u>Cost</u> )			4
5	Short-Term Investments			5
6	Prepaid Insurance	15,948	15,948	6
7	Other Prepaid Expenses	2,108	2,108	7
8	Accounts Receivable (owners or related parties)	2,603,116	2,603,116	8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 3,758,587	\$ 3,758,587	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		44,078	13
14	Buildings, at Historical Cost	941,489	879,222	14
15	Leasehold Improvements, at Historical Cost	229,242	319,822	15
16	Equipment, at Historical Cost	325,803	306,930	16
17	Accumulated Depreciation (book methods)	(630,926)	(664,118)	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):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 865,608	\$ 885,934	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 4,624,195	\$ 4,644,521	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 278,253	\$ 278,253	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	76,507	76,507	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,590	2,590	31
32	Accrued Real Estate Taxes(Sch.IX-B)	27,000	27,000	32
33	Accrued Interest Payable	19,505	19,505	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Payroll Withholdings</u>	22,377	22,377	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 426,232	\$ 426,232	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	13,300	13,300	39
40	Mortgage Payable	2,743,458	2,743,458	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 2,756,758	\$ 2,756,758	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 3,182,990	\$ 3,182,990	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,441,205	\$ 1,461,531	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 4,624,195	\$ 4,644,521	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>960,641</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>960,641</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>480,564</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>480,564</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>1,441,205</b>	<b>24</b> *

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

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

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

1

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 2,748,666	1
2	Discounts and Allowances for all Levels	53,262	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,801,928	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	111,153	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 111,153	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	3,294	14
15	Telephone, Television and Radio	5,436	15
16	Rental of Facility Space		16
17	Sale of Drugs	52,663	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	3,008	20
21	Other Medical Services	15,962	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 80,363	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a	<u>See Attached Schedule 19A</u>	39,602	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 39,602	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,033,046	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	648,905	31
32	Health Care	1,100,358	32
33	General Administration	318,064	33
	<b>B. Capital Expense</b>		
34	Ownership	329,820	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	100,585	35
36	Provider Participation Fee	54,750	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,552,482	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	480,564	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 480,564	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. Facility is a division of a larger entity.

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

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

Arcola Health Care Center

0046045

Period Beginning 01/01/2007

Period End 12/31/2007

Schedule 19A

XVII. INCOME STATEMENT

Line 28a - Other revenue

Miscellaneous	188
Vending	14,761
Gain on Sale of Equipment	<u>24,653</u>
	<u><u>39,602</u></u>

Facility Name & ID Number Arcola Health Care Center

# 0046045

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,080	2,080	\$ 48,500	\$ 23.32	1
2	Assistant Director of Nursing	284	284	5,446	19.18	2
3	Registered Nurses	1,817	2,071	50,638	24.45	3
4	Licensed Practical Nurses	14,666	15,457	253,828	16.42	4
5	CNAs & Orderlies	38,577	39,614	404,929	10.22	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,367	1,493	12,073	8.09	9
10	Activity Assistants	2,690	2,698	23,861	8.84	10
11	Social Service Workers	1,564	1,564	20,452	13.08	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	27,801	13.37	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,739	14,125	106,465	7.54	15
16	Dishwashers					16
17	Maintenance Workers	3,365	3,398	36,024	10.60	17
18	Housekeepers	11,658	12,046	88,598	7.35	18
19	Laundry	6,179	6,219	44,996	7.24	19
20	Administrator	2,080	2,080	41,311	19.86	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,825	1,964	20,353	10.36	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 C: Care Plan Coord.	2,080	2,080	43,128	20.73	32
33	Other(specify) <u>Transportation</u>	1,894	2,062	21,269	10.31	33
34	TOTAL (lines 1 - 33)	107,945	111,315	\$ 1,249,672 *	\$ 11.23	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	16	\$ 840	L2, C3	35
36	Medical Director				36
37	Medical Records Consultant	Monthly	32,400	L9, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,200	L10, C3	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)	16	\$ 34,440		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	2,571	51,420	L10, C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	2,571	\$ 51,420		53

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Sheila Hopkins	Administrator	0	\$ 27,769	Workers' Compensation Insurance	\$ 18,093	IDPH License Fee	\$ 1,990		
Karla Schneider	Administrator	0	13,542	Unemployment Compensation Insurance	22,078	Advertising: Employee Recruitment	164		
				FICA Taxes	93,642	Health Care Worker Background Check (Indicate # of checks performed <u>131</u> )	1,310		
				Employee Health Insurance	58,069	Patient Background Checks			
				Employee Meals		Miscellaneous Licenses & Fees	295		
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Dues & Subscriptions	59		
				Employee Retirement	2,932	LTC Solutions Licensing Fee	1,600		
				Other Employee Benefits	697	IHCA Dues	4,778		
						Home Office Allocation	1,236		
						Less: Public Relations Expense	( )		
						Non-allowable advertising	( )		
						Yellow page advertising	( )		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 41,311	TOTAL (agree to Schedule V, line 22, col.8)		\$ 195,511	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 11,432
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 0				Out-of-State Travel	\$	
							In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$				Seminar Expense		
							Home Office Allocation	876	
							Entertainment Expense	( )	
							(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 8,309	TOTAL		\$	TOTAL	\$ 876	

\* Attach copy of IMRF notifications

\*\*See instructions.

Arcola Health Care Center  
0046045  
Period Beginning 01/01/2007  
Period End 12/31/2007

**Schedule 21A**

**XIX. SUPPORT SCHEDULE**

**C. Professional Services**

<b>Vendor/Payee</b>	<b>Type</b>	<b>Amount</b>
Total (agree to Schedule V, line 19, column 3)		8,309
Non-allowable legal expense		-

**Home Office Allocation**

Pearl & Associates	Legal	37
Addy Bush & Assoc	Legal	19
Registered Agent Solutions	Legal	3
Heyl, Royster, Voelker & Allen	Legal	83
Duane Morris	Legal	128
Ginoli & Co.	Accountants	1,304
RSM McGladrey	Accountants	226
McGladrey & Pullen	Accountants	344
Emdeon Business Services	Computer Services	90
Advanced Answers on Demand	Computer Services	2,420
Access 2 Go	Computer Services	182
Ivans	Computer Services	160
Kemper Technology	Computer Services	379
Adminastar Federal	Computer Services	47
Logmein	Computer Services	30
E-Health Data Solutions	Computer Services	237
Miscellaneous Vendors	Miscellaneous	16

Non-allowable Legal

Total (agree to Schedule V, line 19, column 8)	<u>14,014</u>
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Facility Name &amp; ID Number Arcola Health Care Center

# 0046045

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. IHCA-\$4,778
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 2,459 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 54,750  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 4,691
- (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? Yes  
Firm Name: Ginoli & Co. The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit still in progress
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees