

Facility Name & ID Number El Paso Health Care Center

0046706 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	123	Skilled (SNF)	123	44,895	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	123	TOTALS	123	44,895	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	36,147	1,770	2,935	40,852	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	36,147	1,770	2,935	40,852	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.99%

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 10/20/2004

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

YES

Date 10/20/2004

NO

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

YES

NO

If YES, enter number of beds certified 123 and days of care provided 388

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 El Paso Health Care Center # 0046706 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	172,650	22,042	2,082	196,774		196,774	3,419	200,193		1
2	Food Purchase		220,464		220,464		220,464	(913)	219,551		2
3	Housekeeping	102,404	19,533		121,937		121,937	55	121,992		3
4	Laundry	47,053	7,053		54,106		54,106	2	54,108		4
5	Heat and Other Utilities			150,393	150,393		150,393	584	150,977		5
6	Maintenance	48,043	7,881	28,832	84,756		84,756	4,998	89,754		6
7	Other (specify):* Home Off. Ben. All.							1,560	1,560		7
8	TOTAL General Services	370,150	276,973	181,307	828,430		828,430	9,705	838,135		8
	B. Health Care and Programs										
9	Medical Director			12,960	12,960		12,960		12,960		9
10	Nursing and Medical Records	1,084,986	50,054	48,069	1,183,109		1,183,109	9,082	1,192,191		10
10a	Therapy		137	48,822	48,959		48,959		48,959		10a
11	Activities	46,042	340	406	46,788		46,788	(4,026)	42,762		11
12	Social Services	125,909			125,909		125,909		125,909		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.							2,010	2,010		15
16	TOTAL Health Care and Programs	1,256,937	50,531	110,257	1,417,725		1,417,725	7,066	1,424,791		16
	C. General Administration										
17	Administrative	66,000		83,000	149,000		149,000	(57,552)	91,448		17
18	Directors Fees										18
19	Professional Services			8,738	8,738		8,738	9,320	18,058		19
20	Dues, Fees, Subscriptions & Promotions			5,692	5,692		5,692	1,497	7,189		20
21	Clerical & General Office Expenses	27,973	7,045	15,515	50,533		50,533	62,523	113,056		21
22	Employee Benefits & Payroll Taxes			247,504	247,504		247,504		247,504		22
23	Inservice Training & Education			776	776		776	735	1,511		23
24	Travel and Seminar			745	745		745	1,061	1,806		24
25	Other Admin. Staff Transportation			10,837	10,837		10,837	4,069	14,906		25
26	Insurance-Prop.Liab.Malpractice			29,448	29,448		29,448	1,809	31,257		26
27	Other (specify):* Home Off. Ben. All.							16,568	16,568		27
28	TOTAL General Administration	93,973	7,045	402,255	503,273		503,273	40,030	543,303		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,721,060	334,549	693,819	2,749,428		2,749,428	56,801	2,806,229		29

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

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

Facility Name & ID Number

El Paso Health Care Center

#0046706

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			83,963	83,963		83,963	(10,893)	73,070			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			310,667	310,667		310,667	14,793	325,460			32
33	Real Estate Taxes			143,650	143,650		143,650	1,337	144,987			33
34	Rent-Facility & Grounds							82	82			34
35	Rent-Equipment & Vehicles			4,572	4,572		4,572	1,076	5,648			35
36	Other (specify):*											36
37	TOTAL Ownership			542,852	542,852		542,852	6,395	549,247			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		37,769		37,769		37,769		37,769			39
40	Barber and Beauty Shops			52	52		52		52			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			67,343	67,343		67,343		67,343			42
43	Other (specify):* Non-allowable Cost		9	23,231	23,240		23,240	(23,240)				43
44	TOTAL Special Cost Centers		37,778	90,626	128,404		128,404	(23,240)	105,164			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,721,060	372,327	1,327,297	3,420,684		3,420,684	39,956	3,460,640			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	(1,031)	2		4
5	Telephone, TV & Radio in Resident Rooms	(862)	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	(15,620)	30		9
10	Interest and Other Investment Income	(30)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(5,661)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(100)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(10,137)	43		24
25	Fund Raising, Advertising and Promotional	(3,960)	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 <u>See Pg. 5A</u>	(7,179)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (44,580)		\$	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)	84,536	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 84,536		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 39,956		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

El Paso Health Care Center

ID# 0046706

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (2,249)	43	1
2	X-Rays-Part A	(271)	43	2
3	Offset Transportation Revenue	(4,026)	11	3
4	Offset Miscellaneous Office Supplies Revenue	(633)	21	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(7,179)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number El Paso Health Care Center# 0046706 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	3,419	0	0	0	0	0	0	0	0	0	3,419	1
2	Food Purchase	(1,031)	118	0	0	0	0	0	0	0	0	0	(913)	2
3	Housekeeping	0	39	0	16	0	0	0	0	0	0	0	55	3
4	Laundry	0	2	0	0	0	0	0	0	0	0	0	2	4
5	Heat and Other Utilities	0	584	0	0	0	0	0	0	0	0	0	584	5
6	Maintenance	0	4,762	0	236	0	0	0	0	0	0	0	4,998	6
7	Other (specify):*	0	1,560	0	0	0	0	0	0	0	0	0	1,560	7
8	TOTAL General Services	(1,031)	10,484	0	252	0	9,705	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	9,039	0	43	0	0	0	0	0	0	0	9,082	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(4,026)	0	0	0	0	0	0	0	0	0	0	(4,026)	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	2,010	0	0	0	0	0	0	0	0	0	2,010	15
16	TOTAL Health Care and Programs	(4,026)	11,049	0	43	0	7,066	16						
	C. General Administration													
17	Administrative	0	(57,552)	0	0	0	0	0	0	0	0	0	(57,552)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	6,908	0	2,412	0	0	0	0	0	0	0	9,320	19
20	Fees, Subscriptions & Promotions	0	0	1,497	0	0	0	0	0	0	0	0	1,497	20
21	Clerical & General Office Expenses	(633)	0	57,946	5,210	0	0	0	0	0	0	0	62,523	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	667	68	0	0	0	0	0	0	0	735	23
24	Travel and Seminar	0	0	1,061	0	0	0	0	0	0	0	0	1,061	24
25	Other Admin. Staff Transportation	0	0	3,843	226	0	0	0	0	0	0	0	4,069	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,565	244	0	0	0	0	0	0	0	1,809	26
27	Other (specify):*	0	0	16,568	0	0	0	0	0	0	0	0	16,568	27
28	TOTAL General Administration	(633)	(50,644)	83,147	8,160	0	40,030	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(5,690)	(29,111)	83,147	8,455	0	56,801	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number El Paso Health Care Center# 0046706

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(15,620)	0	4,058	669	0	0	0	0	0	0	0	(10,893)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(30)	0	7,053	7,770	0	0	0	0	0	0	0	14,793	32
33	Real Estate Taxes	0	0	1,337	0	0	0	0	0	0	0	0	1,337	33
34	Rent-Facility & Grounds	0	0	82	0	0	0	0	0	0	0	0	82	34
35	Rent-Equipment & Vehicles	0	0	1,076	0	0	0	0	0	0	0	0	1,076	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(15,650)	0	13,606	8,439	0	6,395	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):*	(23,240)	0	0	0	0	0	0	0	0	0	0	(23,240)	43
44	TOTAL Special Cost Centers	(23,240)	0	0	0	0	0	0	0	0	0	0	(23,240)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(44,580)	(29,111)	96,753	16,894	0	39,956	45						

Facility Name & ID Number

El Paso Health Care Center

0046706

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:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 3,419	\$ 3,419	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	118	118	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	39	39	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	2	2	4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	584	584	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	4,762	4,762	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,560	1,560	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	9,039	9,039	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%	2,010	2,010	10
11	V	17 Administrative	83,000	Petersen Health Care, Inc.	100.00%	25,448	(57,552)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	6,908	6,908	12
13	V							13
14	Total		\$ 83,000			\$ 53,889	\$ * (29,111)	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%	\$ 1,497	\$	1,497	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	57,946		57,946	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	667		667	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	1,061		1,061	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	3,843		3,843	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	1,565		1,565	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	16,568		16,568	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	4,058		4,058	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	7,053		7,053	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	1,337		1,337	24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	82		82	25
26	V	35 Rent-Equipment and Vehicles		Petersen Health Care, Inc.	100.00%	1,076		1,076	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		\$			\$ 96,753	\$ *	96,753	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 Dietary	\$	Petersen Companies, LLC	100.00%	\$ 0	\$ 0 15
16	V	2 Food		Petersen Companies, LLC	100.00%	0	0 16
17	V	3 Housekeeping		Petersen Companies, LLC	100.00%	16	16 17
18	V	4 Laundry		Petersen Companies, LLC	100.00%	0	0 18
19	V	5 Utilities		Petersen Companies, LLC	100.00%	0	0 19
20	V	6 Maintenance		Petersen Companies, LLC	100.00%	236	236 20
21	V	7 Mgmt. Allocation of Benefits		Petersen Companies, LLC	100.00%	0	0 21
22	V	10 Nursing and Medical Records		Petersen Companies, LLC	100.00%	43	43 22
23	V	15 Mgmt. Allocation of Benefits		Petersen Companies, LLC	100.00%	0	0 23
24	V	17 Administrative		Petersen Companies, LLC	100.00%	0	0 24
25	V	19 Professional Services		Petersen Companies, LLC	100.00%	2,412	2,412 25
26	V	20 Dues, Fees, Subs and Promotions		Petersen Companies, LLC	100.00%	0	0 26
27	V	21 Clerical and General Office		Petersen Companies, LLC	100.00%	5,210	5,210 27
28	V	22 Employee Benefits & PR Taxes		Petersen Companies, LLC	100.00%	0	0 28
29	V	23 Inservice Training and Education		Petersen Companies, LLC	100.00%	68	68 29
30	V	24 Travel and Seminar		Petersen Companies, LLC	100.00%	0	0 30
31	V	25 Other Admin. Staff Transportation		Petersen Companies, LLC	100.00%	226	226 31
32	V	26 Insurance-Prop./Liab/Malpractice		Petersen Companies, LLC	100.00%	244	244 32
33	V	27 Mgmt. Allocation of Benefits		Petersen Companies, LLC	100.00%	0	0 33
34	V	30 Depreciation		Petersen Companies, LLC	100.00%	669	669 34
35	V	32 Interest		Petersen Companies, LLC	100.00%	7,770	7,770 35
36	V	33 Real Estate Taxes		Petersen Companies, LLC	100.00%	0	0 36
37	V	34 Rent-Facility and Grounds		Petersen Companies, LLC	100.00%	0	0 37
38	V	35 Rent-Equipment and Vehicles		Petersen Companies, LLC	100.00%	0	0 38
39	Total		\$			\$ 16,894	\$ * 16,894 39

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

Facility Name & ID Number

El Paso Health Care Center

#

0046706

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	1.67	3.04	Salary	\$ 25,448	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	\$ 25,448		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 El Paso Health Care Center

0046706 Report Period Beginning: 01/01/2007

Ending: 2/31/2007

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Petersen Health Care, Inc.
 Street Address 830 W. Trailcreek Drive
 City / State / Zip Code Peoria, IL 61614
 Phone Number (309) 691-8113
 Fax Number (309) 691-8622

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,316,550	66	\$ 110,171	\$ 109,587	40,852	\$ 3,419	1
2	2	Food	Resident Days	1,316,550	66	3,806	0	40,852	118	2
3	3	Housekeeping	Resident Days	1,316,550	66	1,250	0	40,852	39	3
4	4	Laundry	Resident Days	1,316,550	66	73	0	40,852	2	4
5	5	Utilities	Resident Days	1,316,550	66	18,812	0	40,852	584	5
6	6	Maintenance	Resident Days	1,316,550	66	153,468	113,063	40,852	4,762	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	50,271	0	40,852	1,560	7
8	10	Nursing and Medical Records	Resident Days	1,316,550	66	291,305	286,855	40,852	9,039	8
9	10A	Therapy	Resident Days	1,316,550	66	0	0	40,852	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	64,765	0	40,852	2,010	10
11	17	Administrative	Resident Days	1,316,550	66	820,116	820,116	40,852	25,448	11
12	19	Professional Services	Resident Days	1,316,550	66	222,628	0	40,852	6,908	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,316,550	66	48,243	0	40,852	1,497	13
14	21	Clerical and General Office	Resident Days	1,316,550	66	1,867,440	1,544,801	40,852	57,946	14
15	23	Inservice Training & Education	Resident Days	1,316,550	66	21,481	0	40,852	667	15
16	24	Travel and Seminar	Resident Days	1,316,550	66	34,177	0	40,852	1,061	16
17	25	Other Admin. Staff Transport.	Resident Days	1,316,550	66	123,847	0	40,852	3,843	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,316,550	66	50,427	0	40,852	1,565	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	533,953	0	40,852	16,568	19
20	30	Depreciation	Resident Days	1,316,550	66	130,767	0	40,852	4,058	20
21	32	Interest	Resident Days	1,316,550	66	227,295	0	40,852	7,053	21
22	33	Real Estate Taxes	Resident Days	1,316,550	66	43,090	0	40,852	1,337	22
23	34	Rent-Facility and Grounds	Resident Days	1,316,550	66	2,648	0	40,852	82	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,316,550	66	34,690	0	40,852	1,076	24
25	TOTALS					\$ 4,854,723	\$ 2,874,422		\$ 150,642	25

Facility Name & ID Number El Paso Health Care Center

0046706 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 Companies, LLC
 Street Address 830 W. Trailcreek Drive
 City / State / Zip Code Peoria, IL 61614
 Phone Number (309) 691-8113
 Fax Number (309) 691-8622

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	179,368	12	\$	40,852	\$	1
2	2	Food	Resident Days	179,368	12		40,852		2
3	3	Housekeeping	Resident Days	179,368	12	70	40,852	16	3
4	4	Laundry	Resident Days	179,368	12		40,852		4
5	5	Utilities	Resident Days	179,368	12		40,852		5
6	6	Maintenance	Resident Days	179,368	12	1,038	40,852	236	6
7	7	Mgmt. Allocation of Benefits	Resident Days	179,368	12		40,852		7
8	10	Nursing and Medical Records	Resident Days	179,368	12	189	40,852	43	8
9	15	Mgmt. Allocation of Benefits	Resident Days	179,368	12		40,852		9
10	17	Administrative	Resident Days	179,368	12		40,852		10
11	19	Professional Services	Resident Days	179,368	12	10,592	40,852	2,412	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	179,368	12		40,852		12
13	21	Clerical and General Office	Resident Days	179,368	12	22,877	40,852	5,210	13
14	22	Employee Benefits & PR Taxes	Resident Days	179,368	12		40,852		14
15	23	Inservice Training & Education	Resident Days	179,368	12	300	40,852	68	15
16	24	Travel and Seminar	Resident Days	179,368	12		40,852		16
17	25	Other Admin. Staff Transport.	Resident Days	179,368	12	993	40,852	226	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	179,368	12	1,070	40,852	244	18
19	27	Mgmt. Allocation of Benefits	Resident Days	179,368	12		40,852		19
20	30	Depreciation	Resident Days	179,368	12	2,941	40,852	669	20
21	32	Interest	Resident Days	179,368	12	34,114	40,852	7,770	21
22	33	Real Estate Taxes	Resident Days	179,368	12		40,852		22
23	34	Rent-Facility and Grounds	Resident Days	179,368	12		40,852		23
24	35	Rent-Equipment & Vehicles	Resident Days	179,368	12		40,852		24
25	TOTALS					\$ 74,184	\$	\$ 16,894	25

Facility Name & ID Number

El Paso Health Care Center

0046706

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10					
		Related**					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	Associated Bank		X	Mortgage	\$36,061.00	10/20/04	\$ 3,680,000	\$ 3,423,846	01/05/09	0.0830	\$ 293,722	1					
2												2					
3							Interest income offset					(30)	3				
4							Home Office Allocation					14,823	4				
5													5				
Working Capital																	
6													6				
7													7				
8													8				
9	TOTAL Facility Related				\$36,061.00		\$ 3,680,000	\$ 3,423,846			\$ 308,515	9					
B. Non-Facility Related*																	
10													10				
11							Amortization Expense					16,945	11				
12													12				
13													13				
14	TOTAL Non-Facility Related						\$	\$			\$ 16,945	14					
15	TOTALS (line 9+line14)						\$ 3,680,000	\$ 3,423,846			\$ 325,460	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

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

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 El Paso Health Care Center COUNTY Woodford

FACILITY IDPH LICENSE NUMBER 0046706

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>16-04-302-017</u>	<u>Long-Term Care Facility</u>	\$ <u>79,249.02</u>	\$ <u>79,249.02</u>
2. <u>16-04-301-024</u>	<u>Long-Term Care Facility</u>	\$ <u>2,400.50</u>	\$ <u>2,400.50</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>81,649.52</u>	\$ <u>81,649.52</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

Facility Name & ID Number El Paso Health Care Center

0046706

Report Period Beginning:

01/01/2007 Ending:

12/31/2007

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 33,000 B. General Construction Type: Exterior Brick & Block Frame Steel 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>202,500</u>	<u>2004</u>	<u>\$ 50,000</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	202,500		\$ 50,000	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	123	2004	1974	\$ 934,850	\$	35	\$ 26,710	\$ 26,710	\$ 84,582
5									
6									
7	Home Office Allocation			22,775			556	556	
8									
Improvement Type**									
9	Sidewalks		2006	7,230		15	482	482	723
10	Windows		2006	7,500		25	300	300	450
11	Generator		2007	17,756		15	592	592	592
12									
13									
14									
15									
16									
17	Land Improvement Booked in GL				1,446			(1,446)	
18	Building Booked in GL				37,457			(37,457)	
19	Building Improvement Booked in GL				2,347			(2,347)	
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30	2007-Home Office Allocation-Land Improvements			1,524			91	91	
31									
32									
33									
34									
35									
36									

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 991,635	\$ 41,250		\$ 28,731	\$ (12,519)	\$ 86,347	70

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

Facility Name & ID Number El Paso Health Care Center

0046706

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	\$ 273,582	\$ 40,243	\$ 39,083	\$ (1,160)	5-7	\$ 109,926	71
72	Current Year Purchases	23,516	2,470	1,176	(1,294)	10	1,176	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			4,080	4,080			74
75	TOTALS	\$ 297,098	\$ 42,713	\$ 44,339	\$ 1,626		\$ 111,102	75

D. Vehicle Depreciation (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,338,733	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 83,963	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 73,070	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (10,893)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 197,449	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6		<u>Home Office Allocation</u>			<u>82</u>			6
7	TOTAL				\$ <u>82</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: \$ 5,648 Description: See Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18			<u>N/A</u>		18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____ /2008 \$ _____

13. _____ /2009 \$ _____

14. _____ /2010 \$ _____

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

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

El Paso Health Care Center

0046706

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

Dishwasher	1,028
Laundry Equipment	245
Medical Equipment	3,299
Home Office Allocation	<u>1,076</u>
	<u><u>5,648</u></u>

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L. 10A, C. 3	hrs	\$	937	\$ 14,060	\$	937	\$ 14,060	1
2	Licensed Speech and Language Development Therapist	L. 10A ,C. 3	hrs		199	2,986		199	2,986	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L. 10A, C. 2, 3	hrs		2,118	31,776	137	2,118	31,913	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L. 39, C. 2	# of prescripts				37,769		37,769	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			\$	3,254	\$ 48,822	\$ 37,906	3,254	\$ 86,728	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 El Paso Health Care Center

0046706

Report Period Beginning: 01/01/2007

Ending:

12/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 3,427,611	\$ 3,427,611	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>N/A</u>)	680,002	680,002	3
4	Supply Inventory (priced at <u> </u>)			4
5	Short-Term Investments			5
6	Prepaid Insurance	17,773	17,773	6
7	Other Prepaid Expenses	6,177	6,177	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Employee Advances</u>	715	715	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,132,278	\$ 4,132,278	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		50,000	13
14	Buildings, at Historical Cost	992,080	959,149	14
15	Leasehold Improvements, at Historical Cost	25,256	32,486	15
16	Equipment, at Historical Cost	297,098	297,098	16
17	Accumulated Depreciation (book methods)	(248,629)	(197,449)	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>)	8,473	8,473	22
23	Other(specify): <u>Due from Prior Owner</u>	1,438	1,438	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,075,716	\$ 1,151,195	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,207,994	\$ 5,283,473	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 296,031	\$ 296,031	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	115,161	115,161	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,259	4,259	31
32	Accrued Real Estate Taxes(Sch.IX-B)	85,000	85,000	32
33	Accrued Interest Payable	20,524	20,524	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Expenses</u>	33,593	33,593	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 554,568	\$ 554,568	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	3,423,846	3,423,846	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)	\$ 3,423,846	\$ 3,423,846	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,978,414	\$ 3,978,414	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,229,580	\$ 1,305,059	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,207,994	\$ 5,283,473	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 914,236	1
2	Restatements (describe):		2
3	Rounding	(1)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 914,235	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	315,345	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 315,345	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,229,580	24 *

* This must agree with page 17, line 47.

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

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

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,609,969	1
2	Discounts and Allowances for all Levels	39,919	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,649,888	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	71,611	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 71,611	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,031	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	7,367	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	1,019	20
21	Other Medical Services	424	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 9,841	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	30	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 30	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	<u>Miscellaneous Revenue-See Sch. 19A</u>	4,659	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,659	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,736,029	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	828,430	31
32	Health Care	1,417,725	32
33	General Administration	503,273	33
	B. Capital Expense		
34	Ownership	542,852	34
	C. Ancillary Expense		
35	Special Cost Centers	61,061	35
36	Provider Participation Fee	67,343	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,420,684	40
41	Income before Income Taxes (line 30 minus line 40)**	315,345	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 315,345	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.

El Paso Health Care Center

0046706

Period Beginning 01/01/2007

Period End 12/31/2007

Schedule 19A

XVII. INCOME STATEMENT

Line 28a - Other revenue

Transportation 4,026

Office Supplies 633

4,659

Facility Name & ID Number El Paso Health Care Center

0046706

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,892	2,042	\$ 56,732	\$ 27.78	1
2	Assistant Director of Nursing	378	378	9,088	24.04	2
3	Registered Nurses	6,478	6,622	162,497	24.54	3
4	Licensed Practical Nurses	14,469	14,978	311,658	20.81	4
5	CNAs & Orderlies	44,428	45,956	500,137	10.88	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	819	831	7,143	8.60	9
10	Activity Assistants	5,453	5,453	38,899	7.13	10
11	Social Service Workers	9,343	9,423	125,909	13.36	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	35,391	17.01	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,060	17,528	137,259	7.83	15
16	Dishwashers					16
17	Maintenance Workers	3,696	3,975	48,043	12.09	17
18	Housekeepers	12,409	12,579	102,404	8.14	18
19	Laundry	6,091	6,226	47,053	7.56	19
20	Administrator	2,080	2,080	66,000	31.73	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,080	2,080	27,973	13.45	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: <u>Care Plan Coord.</u>	2,175	2,175	44,874	20.63	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	130,931	134,406	\$ 1,721,060 *	\$ 12.80	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	Monthly	\$ 2,082	L. 1, C. 3	35
36	Medical Director	Monthly	12,960	L. 9, C. 3	36
37	Medical Records Consultant	Monthly	720	L. 10, C. 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,150	L. 10, C. 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 16,912		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	608	\$ 21,297	L. 10, C. 3	50
51	Licensed Practical Nurses	703	23,185	L. 10, C. 3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,311	\$ 44,482		53

El Paso Health Care Center
0046706
Period Beginning 01/01/2007
Period End 12/31/2007

Schedule 21A

**XIX. SUPPORT SCHEDULE
C. Professional Services**

Vendor/Payee	Type	Amount
---------------------	-------------	---------------

Total (agree to Schedule V, line 19, column 3)		8,738
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Non-allowable legal expense

Home Office Allocation

Petersen Health Care, Inc

Pearl & Associates	Legal	45
Addy Bush & Assoc	Legal	23
Registered Agent Solutions	Legal	4
Heyl, Royster, Voelker & Allen	Legal	100
Duane Morris	Legal	155
Ginoli & Co.	Accountants	1,579
RSM McGladrey	Accountants	274
McGladrey & Pullen	Accountants	417
Emdeon Business Services	Computer Services	108
Advanced Answers on Demand	Computer Services	2,929
Access 2 Go	Computer Services	221
Ivans	Computer Services	194
Kemper Technology	Computer Services	459
Adminastar Federal	Computer Services	57
Logmeln	Computer Services	36
E-Health Data Solutions	Computer Services	287
Miscellaneous Vendors	Miscellaneous	20

Petersen Companies, LLC

Miscellaneous Vendors	Legal	113
Ginoli & Co.	Accountants	966
McGladrey & Pullen	Accountants	1,333

Non-allowable Legal

Total (agree to Schedule V, line 19, column 8)		<u>18,058</u>
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Facility Name & ID Number El Paso Health Care Center# 0046706Report Period Beginning: 01/01/2007Ending: 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? 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? 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 67,343
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,031
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? 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 \$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