

Facility Name & ID Number Sugar Creek Care Center

0047571 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	13	Skilled (SNF)	13	4,745	1
2		Skilled Pediatric (SNF/PED)			2
3	63	Intermediate (ICF)	63	22,995	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	76	TOTALS	76	27,740	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			1,856	1,856	8
9	SNF/PED					9
10	ICF	5,984	1,955		7,939	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,984	1,955	1,856	9,795	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 35.31%

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 10/1/2005

J. Was the facility purchased or leased after January 1, 1978?
YES Date 10/1/2005 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 13 and days of care provided 1,856

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number Sugar Creek Care Center # 0047571 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	80,753	5,007	449	86,209		86,209	1,972	88,181		1
2	Food Purchase		62,179		62,179		62,179	(3,138)	59,041		2
3	Housekeeping	57,177	6,655		63,832		63,832	9	63,841		3
4	Laundry	13,183	2,839		16,022		16,022	1	16,023		4
5	Heat and Other Utilities			45,078	45,078		45,078	140	45,218		5
6	Maintenance	25,524	5,859	16,707	48,090		48,090	1,150	49,240		6
7	Other (specify):* <u>Home Off. Ben. All.</u>							1,335	1,335		7
8	TOTAL General Services	176,637	82,539	62,234	321,410		321,410	1,469	322,879		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	384,398	27,463	1,222	413,083		413,083	3,521	416,604		10
10a	Therapy		66	117,362	117,428		117,428		117,428		10a
11	Activities	16,670	495	2,398	19,563		19,563		19,563		11
12	Social Services										12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Off. Ben. All.</u>							1,609	1,609		15
16	TOTAL Health Care and Programs	401,068	28,024	126,982	556,074		556,074	5,130	561,204		16
	C. General Administration										
17	Administrative	62,550		28,000	90,550		90,550	(17,190)	73,360		17
18	Directors Fees										18
19	Professional Services			8,225	8,225		8,225	3,016	11,241		19
20	Dues, Fees, Subscriptions & Promotions			7,249	7,249		7,249	245	7,494		20
21	Clerical & General Office Expenses	18,358	2,847	5,394	26,599		26,599	15,173	41,772		21
22	Employee Benefits & Payroll Taxes			98,989	98,989		98,989		98,989		22
23	Inservice Training & Education							160	160		23
24	Travel and Seminar			745	745		745	254	999		24
25	Other Admin. Staff Transportation			1,261	1,261		1,261	1,657	2,918		25
26	Insurance-Prop.Liab.Malpractice			4,606	4,606		4,606	375	4,981		26
27	Other (specify):* <u>Home Off. Ben. All.</u>							7,900	7,900		27
28	TOTAL General Administration	80,908	2,847	154,469	238,224		238,224	11,590	249,814		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	658,613	113,410	343,685	1,115,708		1,115,708	18,189	1,133,897		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

Sugar Creek Care Center

#0047571

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			70,957	70,957		70,957	579	71,536			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			58,655	58,655		58,655	22,053	80,708			32
33	Real Estate Taxes			31,817	31,817		31,817	321	32,138			33
34	Rent-Facility & Grounds							20	20			34
35	Rent-Equipment & Vehicles			6,295	6,295		6,295	258	6,553			35
36	Other (specify):*											36
37	TOTAL Ownership			167,724	167,724		167,724	23,231	190,955			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		40,953		40,953		40,953		40,953			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			41,610	41,610		41,610		41,610			42
43	Other (specify):* Non-allowable Cost		224	59,144	59,368		59,368	(59,368)				43
44	TOTAL Special Cost Centers		41,177	100,754	141,931		141,931	(59,368)	82,563			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	658,613	154,587	612,163	1,425,363		1,425,363	(17,948)	1,407,415			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.

Facility Name & ID Number Sugar Creek Care Center

0047571

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	(3,166)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,286)	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	(950)	30		9
10	Interest and Other Investment Income	(402)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(439)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(49,229)	43		24
25	Fund Raising, Advertising and Promotional	(3,775)	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	(2,829)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (64,076)		\$	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)	46,128	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 46,128		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (17,948)		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

Sugar Creek Care Center

ID# 0047571

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (2,385)	43	1
2	X-Rays-Part A	(254)	43	2
3	Offset Miscellaneous Office Supplies Revenue	(45)	21	3
4	Nonallowable Dues	(145)	20	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	(2,829)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sugar Creek Care Center# 0047571

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	820	0	1,152	0	0	0	0	0	0	0	1,972	1
2	Food Purchase	(3,166)	28	0	0	0	0	0	0	0	0	0	(3,138)	2
3	Housekeeping	0	9	0	0	0	0	0	0	0	0	0	9	3
4	Laundry	0	1	0	0	0	0	0	0	0	0	0	1	4
5	Heat and Other Utilities	0	140	0	0	0	0	0	0	0	0	0	140	5
6	Maintenance	0	1,142	0	8	0	0	0	0	0	0	0	1,150	6
7	Other (specify):*	0	374	0	961	0	0	0	0	0	0	0	1,335	7
8	TOTAL General Services	(3,166)	2,514	0	2,121	0	1,469	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	2,167	0	1,354	0	0	0	0	0	0	0	3,521	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	482	0	1,127	0	0	0	0	0	0	0	1,609	15
16	TOTAL Health Care and Programs	0	2,649	0	2,481	0	5,130	16						
	C. General Administration													
17	Administrative	0	(21,898)	0	4,708	0	0	0	0	0	0	0	(17,190)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	1,656	0	1,360	0	0	0	0	0	0	0	3,016	19
20	Fees, Subscriptions & Promotions	(145)	0	359	31	0	0	0	0	0	0	0	245	20
21	Clerical & General Office Expenses	(45)	0	13,894	1,324	0	0	0	0	0	0	0	15,173	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	160	0	0	0	0	0	0	0	0	160	23
24	Travel and Seminar	0	0	254	0	0	0	0	0	0	0	0	254	24
25	Other Admin. Staff Transportation	0	0	921	736	0	0	0	0	0	0	0	1,657	25
26	Insurance-Prop.Liab.Malpractice	0	0	375	0	0	0	0	0	0	0	0	375	26
27	Other (specify):*	0	0	3,973	3,927	0	0	0	0	0	0	0	7,900	27
28	TOTAL General Administration	(190)	(20,242)	19,936	12,086	0	11,590	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(3,356)	(15,079)	19,936	16,688	0	18,189	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sugar Creek Care Center# 0047571

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	(950)	0	973	556	0	0	0	0	0	0	0	579	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(402)	0	1,691	20,764	0	0	0	0	0	0	0	22,053	32
33	Real Estate Taxes	0	0	321	0	0	0	0	0	0	0	0	321	33
34	Rent-Facility & Grounds	0	0	20	0	0	0	0	0	0	0	0	20	34
35	Rent-Equipment & Vehicles	0	0	258	0	0	0	0	0	0	0	0	258	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(1,352)	0	3,263	21,320	0	23,231	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):*	(59,368)	0	0	0	0	0	0	0	0	0	0	(59,368)	43
44	TOTAL Special Cost Centers	(59,368)	0	0	0	0	0	0	0	0	0	0	(59,368)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(64,076)	(15,079)	23,199	38,008	0	(17,948)	45						

Facility Name & ID Number

Sugar Creek Care Center

0047571

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		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%	\$ 820	\$ 820	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	28	28	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	9	9	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	1	1	4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	140	140	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	1,142	1,142	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	374	374	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	2,167	2,167	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%	482	482	10
11	V	17 Administrative	28,000	Petersen Health Care, Inc.	100.00%	6,102	(21,898)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	1,656	1,656	12
13	V							13
14	Total		\$ 28,000			\$ 12,921	\$ * (15,079)	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 <u>Dues, Fees, Subs and Promotions</u>	\$	<u>Petersen Health Care, Inc.</u>	100.00%	\$ 359	\$	359	15
16	V	21 <u>Clerical and General Office</u>		<u>Petersen Health Care, Inc.</u>	100.00%	13,894		13,894	16
17	V	23 <u>Inservice Training and Education</u>		<u>Petersen Health Care, Inc.</u>	100.00%	160		160	17
18	V	24 <u>Travel and Seminar</u>		<u>Petersen Health Care, Inc.</u>	100.00%	254		254	18
19	V	25 <u>Other Admin. Staff Transportation</u>		<u>Petersen Health Care, Inc.</u>	100.00%	921		921	19
20	V	26 <u>Insurance-Prop./Liab/Malpractice</u>		<u>Petersen Health Care, Inc.</u>	100.00%	375		375	20
21	V	27 <u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Care, Inc.</u>	100.00%	3,973		3,973	21
22	V	30 <u>Depreciation</u>		<u>Petersen Health Care, Inc.</u>	100.00%	973		973	22
23	V	32 <u>Interest</u>		<u>Petersen Health Care, Inc.</u>	100.00%	1,691		1,691	23
24	V	33 <u>Real Estate Taxes</u>		<u>Petersen Health Care, Inc.</u>	100.00%	321		321	24
25	V	34 <u>Rent-Facility and Grounds</u>		<u>Petersen Health Care, Inc.</u>	100.00%	20		20	25
26	V	35 <u>Rent-Equipment and Vehicles</u>		<u>Petersen Health Care, Inc.</u>	100.00%	258		258	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		\$			\$ 23,199	\$ *	23,199	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 <u>Dietary</u>	\$	Petersen Health Operations, LLC	100.00%	\$ 1,152	\$	1,152	15
16	V	2 <u>Food</u>		Petersen Health Operations, LLC	100.00%	0		0	16
17	V	3 <u>Housekeeping</u>		Petersen Health Operations, LLC	100.00%	0		0	17
18	V	4 <u>Laundry</u>		Petersen Health Operations, LLC	100.00%	0		0	18
19	V	5 <u>Utilities</u>		Petersen Health Operations, LLC	100.00%	0		0	19
20	V	6 <u>Maintenance</u>		Petersen Health Operations, LLC	100.00%	8		8	20
21	V	7 <u>Mgmt. Allocation of Benefits</u>		Petersen Health Operations, LLC	100.00%	961		961	21
22	V	10 <u>Nursing and Medical Records</u>		Petersen Health Operations, LLC	100.00%	1,354		1,354	22
23	V	10A <u>Therapy</u>		Petersen Health Operations, LLC	100.00%	0		0	23
24	V	15 <u>Mgmt. Allocation of Benefits</u>		Petersen Health Operations, LLC	100.00%	1,127		1,127	24
25	V	17 <u>Administrative</u>		Petersen Health Operations, LLC	100.00%	4,708		4,708	25
26	V	19 <u>Professional Services</u>		Petersen Health Operations, LLC	100.00%	1,360		1,360	26
27	V	20 <u>Dues, Fees, Subs and Promotions</u>		Petersen Health Operations, LLC	100.00%	31		31	27
28	V	21 <u>Clerical and General Office</u>		Petersen Health Operations, LLC	100.00%	1,324		1,324	28
29	V	23 <u>Inservice Training and Education</u>		Petersen Health Operations, LLC	100.00%	0		0	29
30	V	24 <u>Travel and Seminar</u>		Petersen Health Operations, LLC	100.00%	0		0	30
31	V	25 <u>Other Admin. Staff Transportation</u>		Petersen Health Operations, LLC	100.00%	736		736	31
32	V	26 <u>Insurance-Prop./Liab/Malpractice</u>		Petersen Health Operations, LLC	100.00%	0		0	32
33	V	27 <u>Mgmt. Allocation of Benefits</u>		Petersen Health Operations, LLC	100.00%	3,927		3,927	33
34	V	30 <u>Depreciation</u>		Petersen Health Operations, LLC	100.00%	556		556	34
35	V	32 <u>Interest</u>		Petersen Health Operations, LLC	100.00%	20,764		20,764	35
36	V	33 <u>Real Estate Taxes</u>		Petersen Health Operations, LLC	100.00%	0		0	36
37	V	34 <u>Rent-Facility and Grounds</u>		Petersen Health Operations, LLC	100.00%	0		0	37
38	V	35 <u>Rent-Equipment and Vehicles</u>		Petersen Health Operations, LLC	100.00%	0		0	38
39	Total		\$			\$ 38,008	\$ *	38,008	39

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

Facility Name & ID Number

Sugar Creek Care Center

0047571

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	0.4	0.73	Salary	\$ 6,102	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	\$ 6,102		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 Sugar Creek Care Center# 0047571 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	9,795	\$ 820	1
2	2	Food	Resident Days	1,316,550	66	3,806	0	9,795	28	2
3	3	Housekeeping	Resident Days	1,316,550	66	1,250	0	9,795	9	3
4	4	Laundry	Resident Days	1,316,550	66	73	0	9,795	1	4
5	5	Utilities	Resident Days	1,316,550	66	18,812	0	9,795	140	5
6	6	Maintenance	Resident Days	1,316,550	66	153,468	113,063	9,795	1,142	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	50,271	0	9,795	374	7
8	10	Nursing and Medical Records	Resident Days	1,316,550	66	291,305	286,855	9,795	2,167	8
9	10A	Therapy	Resident Days	1,316,550	66	0	0	9,795	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	64,765	0	9,795	482	10
11	17	Administrative	Resident Days	1,316,550	66	820,116	820,116	9,795	6,102	11
12	19	Professional Services	Resident Days	1,316,550	66	222,628	0	9,795	1,656	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,316,550	66	48,243	0	9,795	359	13
14	21	Clerical and General Office	Resident Days	1,316,550	66	1,867,440	1,544,801	9,795	13,894	14
15	23	Inservice Training & Education	Resident Days	1,316,550	66	21,481	0	9,795	160	15
16	24	Travel and Seminar	Resident Days	1,316,550	66	34,177	0	9,795	254	16
17	25	Other Admin. Staff Transport.	Resident Days	1,316,550	66	123,847	0	9,795	921	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,316,550	66	50,427	0	9,795	375	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	533,953	0	9,795	3,973	19
20	30	Depreciation	Resident Days	1,316,550	66	130,767	0	9,795	973	20
21	32	Interest	Resident Days	1,316,550	66	227,295	0	9,795	1,691	21
22	33	Real Estate Taxes	Resident Days	1,316,550	66	43,090	0	9,795	321	22
23	34	Rent-Facility and Grounds	Resident Days	1,316,550	66	2,648	0	9,795	20	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,316,550	66	34,690	0	9,795	258	24
25	TOTALS					\$ 4,854,723	\$ 2,874,422		\$ 36,120	25

Facility Name & ID Number Sugar Creek Care Center# 0047571 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 Operation, 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	440,525	23	\$ 51,832	\$ 51,832	9,795	\$ 1,152	1
2	2	Food	Resident Days	440,525	23			9,795		2
3	3	Housekeeping	Resident Days	440,525	23			9,795		3
4	4	Laundry	Resident Days	440,525	23			9,795		4
5	5	Utilities	Resident Days	440,525	23			9,795		5
6	6	Maintenance	Resident Days	440,525	23	358		9,795	8	6
7	7	Mgmt. Allocation of Benefits	Resident Days	440,525	23	43,237		9,795	961	7
8	10	Nursing and Medical Records	Resident Days	440,525	23	60,910	60,761	9,795	1,354	8
9	10A	Therapy	Resident Days	440,525	23			9,795		9
10	15	Mgmt. Allocation of Benefits	Resident Days	440,525	23	50,681		9,795	1,127	10
11	17	Administrative	Resident Days	440,525	23	211,751	211,751	9,795	4,708	11
12	19	Professional Services	Resident Days	440,525	23	61,162		9,795	1,360	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	440,525	23	1,373		9,795	31	13
14	21	Clerical and General Office	Resident Days	440,525	23	59,529		9,795	1,324	14
15	23	Inservice Training & Education	Resident Days	440,525	23			9,795		15
16	24	Travel and Seminar	Resident Days	440,525	23	10		9,795		16
17	25	Other Admin. Staff Transport.	Resident Days	440,525	23	33,098		9,795	736	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	440,525	23			9,795		18
19	27	Mgmt. Allocation of Benefits	Resident Days	440,525	23	176,624		9,795	3,927	19
20	30	Depreciation	Resident Days	440,525	23	24,996		9,795	556	20
21	32	Interest	Resident Days	440,525	23	933,842		9,795	20,764	21
22	33	Real Estate Taxes	Resident Days	440,525	23			9,795		22
23	34	Rent-Facility and Grounds	Resident Days	440,525	23			9,795		23
24	35	Rent-Equipment & Vehicles	Resident Days	440,525	23			9,795		24
25	TOTALS					\$ 1,709,403	\$ 324,344		\$ 38,008	25

Facility Name & ID Number

Sugar Creek Care Center

0047571

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**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	LaSalle Bank		X	Mortgage	Varies	1/19/07	\$ 275,000	\$ 271,997	12/31/13	Varies	\$ 58,655	1						
2												2						
3							Offset Interest Income				(402)	3						
4							Home Office Allocation-PHC				1,691	4						
5							Home Office Allocation-PHO				20,764	5						
Working Capital																		
6												6						
7												7						
8												8						
9	TOTAL Facility Related						\$ 275,000	\$ 271,997			\$ 80,708	9						
B. Non-Facility Related*																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 275,000	\$ 271,997			\$ 80,708	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 Sugar Creek Care Center COUNTY Iroquois

FACILITY IDPH LICENSE NUMBER 0047571

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>17C-1931227003</u>	<u>Long-Term Care Facility</u>	\$ <u>30,416.72</u>	\$ <u>30,416.72</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>30,416.72</u>	\$ <u>30,416.72</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 Sugar Creek Care Center

0047571

Report Period Beginning:

01/01/2007 Ending:

12/31/2007

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 16,089 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>98,881</u>	<u>2005</u>	<u>\$ 56,250</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	98,881		\$ 56,250	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	76	2005	1969	\$ 1,008,250	\$	25	\$ 40,330	\$ 40,330	\$ 100,825
5									
6									
7	Home Office Allocation			5,461			133	133	
8									
Improvement Type**									
9									
10	Original Land Improvements	2005		15,000		15	1,000	1,000	2,500
11	Water Heater	2007		4,605		15	154	154	154
12									
13									
14									
15									
16									
17									
18									
19									
20	Land Improvement Booked				1,000			(1,000)	
21	Building Booked				40,357			(40,357)	
22	Building Improvements Booked				384			(384)	
23									
24									
25									
26									
27									
28									
29									
30	2007-Home Office Allocation-Land Improvements			365			22	22	
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)	\$	\$ 1,033,681		\$ 41,639	\$ (102)	\$ 103,479	70

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

Facility Name & ID Number Sugar Creek Care Center

0047571

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	\$ 199,660	\$ 29,216	\$ 28,523	\$ (693)	7	\$ 71,621	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Home Office Allocation			1,374	1,374			74
75	TOTALS	\$ 199,660	\$ 29,216	\$ 29,897	\$ 681		\$ 71,621	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)	\$ 1,289,591	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 70,957	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 71,536	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 579	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 175,100	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>20</u>			6
7	TOTAL				\$ <u>20</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: \$ 6,553 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.

Sugar Creek Care Center

0047571

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	\$	4,389
Dishwasher		601
Medical Equipment		1,305
Home Office Allocation		258
		<u>6,553</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>
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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	\$	3,581	\$ 53,711	\$	3,581	\$ 53,711	1
2	Licensed Speech and Language Development Therapist	L. 10A ,C. 3	hrs		42	636		42	636	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L. 10A, C. 2, 3	hrs		4,201	63,015	66	4,201	63,081	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				40,953		40,953	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			\$	7,824	\$ 117,362	\$ 41,019	7,824	\$ 158,381	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 Sugar Creek Care Center

0047571

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	\$ (1,288,978)	\$ (1,288,978)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>N/A</u>)	321,627	321,627	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	11,011	11,011	6
7	Other Prepaid Expenses	3,821	3,821	7
8	Accounts Receivable (owners or related parties)	(47,312)	(47,312)	8
9	Other(specify): _____			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (999,831)	\$ (999,831)	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		56,250	13
14	Buildings, at Historical Cost	1,079,500	1,014,076	14
15	Leasehold Improvements, at Historical Cost	4,605	19,605	15
16	Equipment, at Historical Cost	199,660	199,660	16
17	Accumulated Depreciation (book methods)	(156,511)	(175,100)	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	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,127,254	\$ 1,114,491	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 127,423	\$ 114,660	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 156,361	\$ 156,361	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	13,862	13,862	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,793	4,793	31
32	Accrued Real Estate Taxes(Sch.IX-B)	32,000	32,000	32
33	Accrued Interest Payable	1,707	1,707	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued expenses</u>	12,258	12,258	36
37	_____			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 220,981	\$ 220,981	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	271,997	271,997	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Due to Prior owner</u>	2,412	2,412	43
44	_____			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 274,409	\$ 274,409	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 495,390	\$ 495,390	46
47	TOTAL EQUITY(page 18, line 24)	\$ (367,967)	\$ (380,730)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 127,423	\$ 114,660	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (346,770)	1
2	Restatements (describe):		2
3	<u>Rounding</u>	<u>2</u>	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (346,768)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(21,199)	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)	\$ (21,199)	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)	\$ (367,967)	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	\$ 992,497	1
2	Discounts and Allowances for all Levels	134,601	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,127,098	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	165,316	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 165,316	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	3,166	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	69,943	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	6,886	20
21	Other Medical Services	31,308	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 111,303	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	402	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 402	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	<u>Miscellaneous Revenue</u>	45	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 45	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,404,164	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	321,410	31
32	Health Care	556,074	32
33	General Administration	238,224	33
	B. Capital Expense		
34	Ownership	167,724	34
	C. Ancillary Expense		
35	Special Cost Centers	100,321	35
36	Provider Participation Fee	41,610	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,425,363	40
41	Income before Income Taxes (line 30 minus line 40)**	(21,199)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (21,199)	43

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

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

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

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

Facility Name & ID Number Sugar Creek Care Center

0047571

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	1,175	\$ 27,633	\$ 23.52	1
2	Assistant Director of Nursing				2
3	Registered Nurses	1,372	32,101	21.84	3
4	Licensed Practical Nurses	8,638	160,217	18.09	4
5	CNAs & Orderlies	17,876	164,447	8.91	5
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director	1,776	16,670	9.26	9
10	Activity Assistants				10
11	Social Service Workers				11
12	Dietician				12
13	Food Service Supervisor	2,069	19,919	9.34	13
14	Head Cook				14
15	Cook Helpers/Assistants	8,186	60,834	7.39	15
16	Dishwashers				16
17	Maintenance Workers	1,978	25,524	12.45	17
18	Housekeepers	7,971	57,177	7.06	18
19	Laundry	1,728	13,183	7.23	19
20	Administrator	2,152	62,550	29.07	20
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical	1,961	18,358	9.12	24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)				28
29	Resident Services Coordinator				29
30	Habilitation Aides (DD Homes)				30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	56,882	\$ 658,613 *	\$ 11.31	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 \$ 449	L. 1, C. 3	35
36	Medical Director	Monthly 6,000	L. 9, C. 3	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 1,142	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)	\$ 7,591		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Donna Jenkins	Administrator	0	\$ 23,796	Workers' Compensation Insurance	\$ 9,827	IDPH License Fee	\$ 1,870	
Jason Hirsbrunner	Administrator	0	35,004	Unemployment Compensation Insurance	32,527	Advertising: Employee Recruitment	352	
Paula Deddo	Administrator	0	3,750	FICA Taxes	49,245	Health Care Worker Background Check	680	
				Employee Health Insurance	2,893	(Indicate # of checks performed <u>68</u>)		
				Employee Meals		LTC Solutions License	1,600	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Dues & Licenses	704	
						IHCA	2,043	
TOTAL (agree to Schedule V, line 17, col. 1)				Employee Retirement	379	Home Office Allocation	390	
(List each licensed administrator separately.)			\$ 62,550	Employee Relations	4,118			
B. Administrative - Other								
Description			Amount					
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 28,000					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 28,000	TOTAL (agree to Schedule V, line 22, col.8)			\$ 98,989	
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type	Amount	Description	Line #	Amount	Description	Amount	
McGladrey & Pullen, LLP	Accounting	\$ 6,080				Out-of-State Travel	\$	
E-Health Data Solutions	Computer Services	2,025						
AT&T	Computer Services	120	N/A			In-State Travel		
						Seminar Expense	745	
						Home Office Allocation	254	
						Entertainment Expense	()	
						(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			\$	999
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 8,225					

* Attach copy of IMRF notifications

**See instructions.

Sugar Creek Care Center
 0047571
 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)		8,225

Non-allowable legal expense

Home Office Allocation

Petersen Health Care, Inc

Pearl & Associates	Legal	11
Addy Bush & Assoc	Legal	5
Registered Agent Solutions	Legal	1
Heyl, Royster, Voelker & Allen	Legal	24
Duane Morris	Legal	37
Ginoli & Co.	Accountants	379
RSM McGladrey	Accountants	66
McGladrey & Pullen	Accountants	100
Emdeon Business Services	Computer Services	26
Advanced Answers on Demand	Computer Services	702
Access 2 Go	Computer Services	53
Ivans	Computer Services	46
Kemper Technology	Computer Services	110
Adminastar Federal	Computer Services	14
Logmein	Computer Services	9
E-Health Data Solutions	Computer Services	69
Miscellaneous Vendors	Miscellaneous	4

Petersen Health Operations, LLC

Ginoli & Co.	Accountants	841
Julie Breedlove	Computer Services	8
Ivans	Computer Services	189
Miscellaneous Vendors	Computer Services	3
Amerisearch	Employment fees	319

Non-allowable Legal

Total (agree to Schedule V, line 19, column 8)	<u>11,241</u>
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Facility Name & ID Number Sugar Creek Care Center# 0047571Report 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? Yes
If YES, give association name and amount. IHCA \$2043
- (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. \$ 3,640 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. \$ 41,610
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. \$ 3,166
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli & 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 currently 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