



Facility Name & ID Number Tuscola Health Care Center

# 0046805 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	<u>21</u>	Skilled (SNF)	<u>21</u>	<u>7,665</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>52</u>	Intermediate (ICF)	<u>52</u>	<u>18,980</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>73</u>	TOTALS	<u>73</u>	<u>26,645</u>	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			<u>2,365</u>	<u>2,365</u>	8
9	SNF/PED					9
10	ICF	<u>11,168</u>	<u>6,439</u>		<u>17,607</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>11,168</u>	<u>6,439</u>	<u>2,365</u>	<u>19,972</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.96%

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)

Home Care

F. Does the facility maintain a daily midnight census?

Yes

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

YES

NO

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

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

YES

NO

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

Date started 8/01/04

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

YES

Date 1/18/05

NO

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

YES

NO

If YES, enter number of beds certified 21 and days of care provided 2,365

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 Tuscola Health Care Center # 0046805 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	109,773	11,207	3,780	124,760		124,760	1,671	126,431		1
2	Food Purchase		99,626		99,626		99,626	(3,495)	96,131		2
3	Housekeeping	78,970	11,371		90,341		90,341	19	90,360		3
4	Laundry	21,279	5,252		26,531		26,531	1	26,532		4
5	Heat and Other Utilities			67,152	67,152		67,152	285	67,437		5
6	Maintenance	25,792	13,686	16,293	55,771		55,771	2,328	58,099		6
7	Other (specify):* <u>Home Off. Ben. All.</u>							763	763		7
8	<b>TOTAL General Services</b>	235,814	141,142	87,225	464,181		464,181	1,572	465,753		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			8,400	8,400		8,400		8,400		9
10	Nursing and Medical Records	737,843	73,306	14,065	825,214		825,214	(1,838)	823,376		10
10a	Therapy		740	138,609	139,349		139,349		139,349		10a
11	Activities	26,478	390	1,012	27,880		27,880		27,880		11
12	Social Services	26,331			26,331		26,331		26,331		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Off. Ben. All.</u>							983	983		15
16	<b>TOTAL Health Care and Programs</b>	790,652	74,436	162,086	1,027,174		1,027,174	(855)	1,026,319		16
	<b>C. General Administration</b>										
17	Administrative	55,625		77,500	133,125		133,125	(65,059)	68,066		17
18	Directors Fees										18
19	Professional Services			10,167	10,167		10,167	5,189	15,356		19
20	Dues, Fees, Subscriptions & Promotions			8,729	8,729		8,729	557	9,286		20
21	Clerical & General Office Expenses	32,431	5,170	6,755	44,356		44,356	31,089	75,445		21
22	Employee Benefits & Payroll Taxes			230,697	230,697		230,697	10,960	241,657		22
23	Inservice Training & Education			765	765		765	396	1,161		23
24	Travel and Seminar							519	519		24
25	Other Admin. Staff Transportation			4,058	4,058		4,058	1,879	5,937		25
26	Insurance-Prop.Liab.Malpractice			13,544	13,544		13,544	1,435	14,979		26
27	Other (specify):* <u>Home Off. Ben. All.</u>							8,100	8,100		27
28	<b>TOTAL General Administration</b>	88,056	5,170	352,215	445,441		445,441	(4,935)	440,506		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,114,522	220,748	601,526	1,936,796		1,936,796	(4,218)	1,932,578		29

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

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

Facility Name &amp; ID Number Tuscola Health Care Center

#0046805

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			46,138	46,138		46,138	781	46,919			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			70,457	70,457		70,457	10,485	80,942			32
33	Real Estate Taxes			28,960	28,960		28,960	654	29,614			33
34	Rent-Facility & Grounds							40	40			34
35	Rent-Equipment & Vehicles			43,012	43,012		43,012	526	43,538			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			188,567	188,567		188,567	12,486	201,053			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		66,511		66,511		66,511		66,511			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			39,968	39,968		39,968		39,968			42
43	Other (specify):* Non-allowable Cost		176	41,354	41,530		41,530	(41,530)				43
44	<b>TOTAL Special Cost Centers</b>		66,687	81,322	148,009		148,009	(41,530)	106,479			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,114,522	287,435	871,415	2,273,372		2,273,372	(33,262)	2,240,110			45

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

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

**VI. ADJUSTMENT DETAIL**

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,553)	2		4
5	Telephone, TV & Radio in Resident Rooms	(260)	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	(1,203)	30		9
10	Interest and Other Investment Income	(1,040)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(549)	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	(1,200)	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	(38,886)	43		24
25	Fund Raising, Advertising and Promotional	(7,800)	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>	603	Various		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (53,888)		\$	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)	20,626	Various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 20,626		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (33,262)		37

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

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

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

Tuscola Health Care Center

ID# 0046805

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ 5,451	43	1
2	X-Rays-Part A	3,005	43	2
3	Offset Miscellaneous Nursing Supplies Revenue	(1,428)	10	3
4	Offset Miscellaneous Nursing Salaries Revenue	(4,829)	10	4
5	Offset Miscellaneous Office Supplies Revenue	(105)	21	5
6	Offset Chamber of Commerce Dues	(200)	20	6
7	Resident Flower	(338)	43	7
8	Disallowed Special Events	(953)	43	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	603		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Tuscola Health Care Center

# 0046805

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	1,671	0	0	0	0	0	0	0	0	0	1,671	1
2	Food Purchase	(3,553)	58	0	0	0	0	0	0	0	0	0	(3,495)	2
3	Housekeeping	0	19	0	0	0	0	0	0	0	0	0	19	3
4	Laundry	0	1	0	0	0	0	0	0	0	0	0	1	4
5	Heat and Other Utilities	0	285	0	0	0	0	0	0	0	0	0	285	5
6	Maintenance	0	2,328	0	0	0	0	0	0	0	0	0	2,328	6
7	Other (specify):*	0	763	0	0	0	0	0	0	0	0	0	763	7
8	<b>TOTAL General Services</b>	<b>(3,553)</b>	<b>5,125</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1,572</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(6,257)	4,419	0	0	0	0	0	0	0	0	0	(1,838)	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	983	0	0	0	0	0	0	0	0	0	983	15
16	<b>TOTAL Health Care and Programs</b>	<b>(6,257)</b>	<b>5,402</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(855)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(65,059)	0	0	0	0	0	0	0	0	0	(65,059)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	3,377	0	1,812	0	0	0	0	0	0	0	5,189	19
20	Fees, Subscriptions & Promotions	(200)	0	732	25	0	0	0	0	0	0	0	557	20
21	Clerical & General Office Expenses	(105)	0	28,329	2,865	0	0	0	0	0	0	0	31,089	21
22	Employee Benefits & Payroll Taxes	0	0	0	10,960	0	0	0	0	0	0	0	10,960	22
23	Inservice Training & Education	0	0	326	70	0	0	0	0	0	0	0	396	23
24	Travel and Seminar	0	0	519	0	0	0	0	0	0	0	0	519	24
25	Other Admin. Staff Transportation	0	0	1,879	0	0	0	0	0	0	0	0	1,879	25
26	Insurance-Prop.Liab.Malpractice	0	0	765	670	0	0	0	0	0	0	0	1,435	26
27	Other (specify):*	0	0	8,100	0	0	0	0	0	0	0	0	8,100	27
28	<b>TOTAL General Administration</b>	<b>(305)</b>	<b>(61,682)</b>	<b>40,650</b>	<b>16,402</b>	<b>0</b>	<b>(4,935)</b>	<b>28</b>						
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(10,115)</b>	<b>(51,155)</b>	<b>40,650</b>	<b>16,402</b>	<b>0</b>	<b>(4,218)</b>	<b>29</b>						

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Tuscola Health Care Center# 0046805

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	(1,203)	0	1,984	0	0	0	0	0	0	0	0	781	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,040)	0	3,448	8,077	0	0	0	0	0	0	0	10,485	32
33	Real Estate Taxes	0	0	654	0	0	0	0	0	0	0	0	654	33
34	Rent-Facility & Grounds	0	0	40	0	0	0	0	0	0	0	0	40	34
35	Rent-Equipment & Vehicles	0	0	526	0	0	0	0	0	0	0	0	526	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(2,243)</b>	<b>0</b>	<b>6,652</b>	<b>8,077</b>	<b>0</b>	<b>12,486</b>	<b>37</b>						
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(41,530)	0	0	0	0	0	0	0	0	0	0	(41,530)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(41,530)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(41,530)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(53,888)</b>	<b>(51,155)</b>	<b>47,302</b>	<b>24,479</b>	<b>0</b>	<b>(33,262)</b>	<b>45</b>						

Facility Name & ID Number

Tuscola Health Care Center

# 0046805

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	70	See Attached Schedule 6E		See Attached Sch 6E		
Jifi Jacob	10					
Jacque Whitley	10					
Cindy White	10					

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 1,671	\$ 1,671	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	58	58	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	19	19	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	1	1	4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	285	285	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	2,328	2,328	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	763	763	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	4,419	4,419	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%	983	983	10
11	V	17 Administrative	77,500	Petersen Health Care, Inc.	100.00%	12,441	(65,059)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	3,377	3,377	12
13	V							13
14	Total		\$ 77,500			\$ 26,345	\$ * (51,155)	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%	\$ 732	\$	732	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	28,329		28,329	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	326		326	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	519		519	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	1,879		1,879	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	765		765	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	8,100		8,100	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	1,984		1,984	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	3,448		3,448	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	654		654	24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	40		40	25
26	V	35 Rent-Equipment and Vehicles		Petersen Health Care, Inc.	100.00%	526		526	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	<b>Total</b>		\$			\$ 47,302	\$ *	47,302	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>	\$	<u>Petersen Health Enterprises, LLC</u>	100.00%	\$ 0	\$	0	15
16	V	2 <u>Food</u>		<u>Petersen Health Enterprises, LLC</u>	100.00%	0		0	16
17	V	3 <u>Housekeeping</u>		<u>Petersen Health Enterprises, LLC</u>	100.00%	0		0	17
18	V	4 <u>Laundry</u>		<u>Petersen Health Enterprises, LLC</u>	100.00%	0		0	18
19	V	5 <u>Utilities</u>		<u>Petersen Health Enterprises, LLC</u>	100.00%	0		0	19
20	V	6 <u>Maintenance</u>		<u>Petersen Health Enterprises, LLC</u>	100.00%	0		0	20
21	V	7 <u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Enterprises, LLC</u>	100.00%	0		0	21
22	V	10 <u>Nursing and Medical Records</u>		<u>Petersen Health Enterprises, LLC</u>	100.00%	0		0	22
23	V	15 <u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Enterprises, LLC</u>	100.00%	0		0	23
24	V	17 <u>Administrative</u>		<u>Petersen Health Enterprises, LLC</u>	100.00%	0		0	24
25	V	19 <u>Professional Services</u>		<u>Petersen Health Enterprises, LLC</u>	100.00%	1,812		1,812	25
26	V	20 <u>Dues, Fees, Subs and Promotions</u>		<u>Petersen Health Enterprises, LLC</u>	100.00%	25		25	26
27	V	21 <u>Clerical and General Office</u>		<u>Petersen Health Enterprises, LLC</u>	100.00%	2,865		2,865	27
28	V	22 <u>Employee Benefits &amp; Payroll</u>		<u>Petersen Health Enterprises, LLC</u>	100.00%	10,960		10,960	28
29	V	23 <u>Inservice Training and Education</u>		<u>Petersen Health Enterprises, LLC</u>	100.00%	70		70	29
30	V	24 <u>Travel and Seminar</u>		<u>Petersen Health Enterprises, LLC</u>	100.00%	0		0	30
31	V	25 <u>Other Admin. Staff Transportation</u>		<u>Petersen Health Enterprises, LLC</u>	100.00%	0		0	31
32	V	26 <u>Insurance-Prop./Liab/Malpractice</u>		<u>Petersen Health Enterprises, LLC</u>	100.00%	670		670	32
33	V	27 <u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Enterprises, LLC</u>	100.00%	0		0	33
34	V	30 <u>Depreciation</u>		<u>Petersen Health Enterprises, LLC</u>	100.00%	0		0	34
35	V	32 <u>Interest</u>		<u>Petersen Health Enterprises, LLC</u>	100.00%	8,077		8,077	35
36	V	33 <u>Real Estate Taxes</u>		<u>Petersen Health Enterprises, LLC</u>	100.00%	0		0	36
37	V	34 <u>Rent-Facility and Grounds</u>		<u>Petersen Health Enterprises, LLC</u>	100.00%	0		0	37
38	V	35 <u>Rent-Equipment and Vehicles</u>		<u>Petersen Health Enterprises, LLC</u>	100.00%	0		0	38
39	<b>Total</b>		\$			\$ 24,479	\$ *	24,479	39

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

Facility Name &amp; ID Number

Tuscola Health Care Center

# 0046805

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	70.00	See Schedule 7A	0.82	1.49	Salary	\$ 12,441	L17, C7	1
2	Jifi C. Jacob	Owner	Administrative	10.00	See Schedule 7A	0.84	1.52	Salary	821	L21, C7	2
3	Jacque Whitley	Owner	Administrative	10.00	See Schedule 7A	0.84	1.52	Salary	1,661	L21, C7	3
4	Cindy White	Owner	Administrative	10.00	See Schedule 7A	0.84	1.52	Salary	2,048	L21, C7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 16,971		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 Tuscola Health Care Center# 0046805 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	19,972	\$ 1,671	1
2	2	Food	Resident Days	1,316,550	66	3,806	0	19,972	58	2
3	3	Housekeeping	Resident Days	1,316,550	66	1,250	0	19,972	19	3
4	4	Laundry	Resident Days	1,316,550	66	73	0	19,972	1	4
5	5	Utilities	Resident Days	1,316,550	66	18,812	0	19,972	285	5
6	6	Maintenance	Resident Days	1,316,550	66	153,468	113,063	19,972	2,328	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	50,271	0	19,972	763	7
8	10	Nursing and Medical Records	Resident Days	1,316,550	66	291,305	286,855	19,972	4,419	8
9	10A	Therapy	Resident Days	1,316,550	66	0	0	19,972	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	64,765	0	19,972	983	10
11	17	Administrative	Resident Days	1,316,550	66	820,116	820,116	19,972	12,441	11
12	19	Professional Services	Resident Days	1,316,550	66	222,628	0	19,972	3,377	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,316,550	66	48,243	0	19,972	732	13
14	21	Clerical and General Office	Resident Days	1,316,550	66	1,867,440	1,544,801	19,972	28,329	14
15	23	Inservice Training & Education	Resident Days	1,316,550	66	21,481	0	19,972	326	15
16	24	Travel and Seminar	Resident Days	1,316,550	66	34,177	0	19,972	519	16
17	25	Other Admin. Staff Transport.	Resident Days	1,316,550	66	123,847	0	19,972	1,879	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,316,550	66	50,427	0	19,972	765	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	533,953	0	19,972	8,100	19
20	30	Depreciation	Resident Days	1,316,550	66	130,767	0	19,972	1,984	20
21	32	Interest	Resident Days	1,316,550	66	227,295	0	19,972	3,448	21
22	33	Real Estate Taxes	Resident Days	1,316,550	66	43,090	0	19,972	654	22
23	34	Rent-Facility and Grounds	Resident Days	1,316,550	66	2,648	0	19,972	40	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,316,550	66	34,690	0	19,972	526	24
25	TOTALS					\$ 4,854,723	\$ 2,874,422		\$ 73,647	25

Facility Name & ID Number Tuscola Health Care Center

# 0046805

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

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	86,155	5	\$	19,972	\$	1
2	2	Food	Resident Days	86,155	5		19,972		2
3	3	Housekeeping	Resident Days	86,155	5		19,972		3
4	4	Laundry	Resident Days	86,155	5		19,972		4
5	5	Utilities	Resident Days	86,155	5		19,972		5
6	6	Maintenance	Resident Days	86,155	5		19,972		6
7	7	Mgmt. Allocation of Benefits	Resident Days	86,155	5		19,972		7
8	10	Nursing and Medical Records	Resident Days	86,155	5		19,972		8
9	15	Mgmt. Allocation of Benefits	Resident Days	86,155	5		19,972		9
10	17	Administrative	Resident Days	86,155	5		19,972		10
11	19	Professional Services	Resident Days	86,155	5	7,818	19,972	1,812	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	86,155	5	110	19,972	25	12
13	21	Clerical and General Office	Resident Days	86,155	5	12,357	19,972	2,865	13
14	22	Employee Benefits & Payroll	Resident Days	86,155	5	47,280	19,972	10,960	14
15	23	Inservice Training & Education	Resident Days	86,155	5	300	19,972	70	15
16	24	Travel and Seminar	Resident Days	86,155	5		19,972		16
17	25	Other Admin. Staff Transport.	Resident Days	86,155	5		19,972		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	86,155	5	2,889	19,972	670	18
19	27	Mgmt. Allocation of Benefits	Resident Days	86,155	5		19,972		19
20	30	Depreciation	Resident Days	86,155	5		19,972		20
21	32	Interest	Resident Days	86,155	5	34,841	19,972	8,077	21
22	33	Real Estate Taxes	Resident Days	86,155	5		19,972		22
23	34	Rent-Facility and Grounds	Resident Days	86,155	5		19,972		23
24	35	Rent-Equipment & Vehicles	Resident Days	86,155	5		19,972		24
25	TOTALS					\$ 105,595	\$	\$ 24,479	25

Facility Name & ID Number

Tuscola Health Care Center

# 0046805

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			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	F & M Bank of Galesburg, IL		X	Mortgage	\$5,744.00	5/6/2005	\$ 708,120	\$ 666,797	5/6/2008	0.0748	\$ 50,580	1						
2	F & M Bank of Galesburg, IL		X	Purchase Van	\$566.00	9/30/2005	28,696	16,997	9/30/2010	0.0675	1,373	2						
3							Interest Income Offset				(1,040)	3						
4							Home Office Allocation-PHC				3,448	4						
5							Home Office Allocation-PHE				8,077	5						
<b>Working Capital</b>																		
6												6						
7												7						
8												8						
9	<b>TOTAL Facility Related</b>				<b>\$6,310.00</b>		<b>\$ 736,816</b>	<b>\$ 683,794</b>			<b>\$ 62,438</b>	<b>9</b>						
<b>B. Non-Facility Related*</b>																		
10												10						
11							Amortization of Mortgage Costs				18,504	11						
12												12						
13												13						
14	<b>TOTAL Non-Facility Related</b>						<b>\$</b>	<b>\$</b>			<b>\$ 18,504</b>	<b>14</b>						
15	<b>TOTALS (line 9+line14)</b>						<b>\$ 736,816</b>	<b>\$ 683,794</b>			<b>\$ 80,942</b>	<b>15</b>						

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

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

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

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)**

**B. Real Estate Taxes**

**Important**, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2006 report.		\$	<b>28,191</b>	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2006	\$	<b>28,151</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(40)</b>	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>29,000</b>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>Home Office Allocation</b>			<b>654</b>	
<b>TOTAL REFUND</b> \$ _____ For _____ Tax Year. <b>(Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>29,614</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2002	<b>24,507</b>	8
	2003	<b>25,933</b>	9
	2004	<b>27,332</b>	10
	2005	<b>28,191</b>	11
	2006	<b>28,151</b>	12

**Accrual based on prior year tax bill.**

<b>FOR BHF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 2006	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 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 Tuscola Health Care Center COUNTY Douglas

FACILITY IDPH LICENSE NUMBER 0046805

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

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

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

Enter the tax index number and real estate tax assessed for 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>09-08-02-100-027</u>	<u>Long-Term Care Facility</u>	\$ <u>15,103.00</u>	\$ <u>15,103.00</u>
2. <u>09-08-02-100-029</u>	<u>Long-Term Care Facility</u>	\$ <u>13,048.00</u>	\$ <u>13,048.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>28,151.00</u>	\$ <u>28,151.00</u>

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

Attach a copy of the original 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 Tuscola Health Care Center

# 0046805

Report Period Beginning:

01/01/2007 Ending:

12/31/2007

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 21,274 B. General Construction Type: Exterior Brick 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>187,955</u>	<u>2005</u>	<u>\$ 50,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>187,955</b>		<b>\$ 50,000</b>	<b>3</b>

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	73	2005	1974	\$ 500,000	\$	30	\$ 16,667	\$ 16,667	\$ 50,002	4
5										5
6										6
7	Home Office Allocation			11,134			272			7
8										8
<b>Improvement Type**</b>										
9	Carpeting		2005	1,286		25	51	51	145	9
10	Tiles		2005	2,945		10	295	295	835	10
11	Sidewalks		2005	3,901		15	260	260	650	11
12	Fire Alarm System		2006	4,552		5	910	910	1,365	12
13	Carpeting		2007	1,152		10	58	58	58	13
14	Signage		2007	3,305		10	165	165	165	14
15	Parking Lot		2007	2,400		15	80	80	80	15
16										16
17										17
18	Building Booked				16,667			(16,667)		18
19	Building Improvement Booked				1,720			(1,720)		19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31	2007-Home Office Allocation-Building Improvements			745			44	44		31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

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)	\$	\$ 531,420		\$ 18,802	\$ 143	\$ 53,300	70

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

Facility Name & ID Number Tuscola Health Care Center

# 0046805

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	\$ 178,533	\$ 19,444	\$ 19,341	\$ (103)	5-10	\$ 54,033	71
72	Current Year Purchases	27,385	2,568	1,369	(1,199)	10	1,369	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			1,668	1,668			74
75	TOTALS	\$ 205,918	\$ 22,012	\$ 22,378	\$ 366		\$ 55,402	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	'06 Ford Econoline	2005	\$ 28,696	\$ 5,739	\$ 5,739	\$	5	\$ 12,913	76
77										77
78										78
79										79
80	TOTALS			\$ 28,696	\$ 5,739	\$ 5,739	\$		\$ 12,913	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)	\$ 816,034	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 46,138	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 46,919	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 781	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 121,615	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>40</u>			6
7	TOTAL				\$ <u>40</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: \$ 43,538 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.

**Tuscola Health Care Center**

**0046805**

**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**

Medical Equipment	\$ 40,011
Dishwasher	150
Laundry Equipment	150
Maintenance Equipment	73
Copier	2,628
Home Office Allocation	526
	<u>43,538</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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><b>2. CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	4,478	\$ 67,169	\$	4,478	\$ 67,169	1
2	Licensed Speech and Language Development Therapist	10A3)	hrs		374	5,606		374	5,606	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		4,387	65,799	740	4,387	66,539	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescripts				66,511		66,511	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): <u>Respiratory Therapy</u>				2	35		2	35	13
14	<b>TOTAL</b>			\$	9,241	\$ 138,609	\$ 67,251	9,241	\$ 205,860	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.



Tuscola Health Care Center  
 0046805  
 Period Beginning 01/01/2007  
 Period End 12/31/2007

**Schedule 17A**

**XV. Balance Sheet**

**Long Term Assets**

**Line 23 - Other Long-Term Assets**

	Operating	After Consolidation
Mortgage Escrows		
Due from Related Party		
<b>Total Line 23 Other Long-Term Assets</b>	<u>-</u>	<u>-</u>

**XV. Balance Sheet**

**Current Liabilities**

**Line 36 - Other Current Liabilities**

	Operating	After Consolidation
Resident Credit Balances		
Accrued Rent		
<b>Total Line 36 Other Current Liabilities</b>	<u>-</u>	<u>-</u>

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(55,079)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<u>Rounding</u>	<u>1</u>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(55,078)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>213,057</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>213,057</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>157,979</b>	<b>24</b> *

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

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached. Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

1

Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 1,986,526	1
2	Discounts and Allowances for all Levels	103,698	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,090,224	3
<b>B. Ancillary Revenue</b>			
4	Day Care	3,055	4
5	Other Care for Outpatients		5
6	Therapy	260,973	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 264,028	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	3,553	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	112,613	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	4,841	20
21	Other Medical Services	3,768	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 124,775	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	1,040	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 1,040	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Miscellaneous Revenue</b>	6,362	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 6,362	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,486,429	30

2

Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	464,181	31
32	Health Care	1,027,174	32
33	General Administration	445,441	33
<b>B. Capital Expense</b>			
34	Ownership	188,567	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	108,041	35
36	Provider Participation Fee	39,968	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,273,372	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	213,057	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 213,057	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 Tuscola Health Care Center

# 0046805

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,004	2,012	\$ 46,562	\$ 23.14	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,569	7,042	148,852	21.14	3
4	Licensed Practical Nurses	8,303	8,543	148,225	17.35	4
5	CNAs & Orderlies	32,019	33,303	346,815	10.41	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,844	1,929	15,584	8.08	9
10	Activity Assistants					10
11	Social Service Workers	2,095	2,103	26,331	12.52	11
12	Dietician					12
13	Food Service Supervisor	1,687	1,783	23,187	13.00	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,054	10,406	86,586	8.32	15
16	Dishwashers					16
17	Maintenance Workers	2,080	2,080	25,792	12.40	17
18	Housekeepers	7,791	8,305	78,970	9.51	18
19	Laundry	1,843	1,995	21,279	10.67	19
20	Administrator	2,080	2,080	55,625	26.74	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,879	2,095	32,431	15.48	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Sch. 20A</u>	3,766	4,006	58,283	14.55	33
34	TOTAL (lines 1 - 33)	84,014	87,682	\$ 1,114,522 *	\$ 12.71	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	72 hrs.	\$ 3,780	1(3)	35
36	Medical Director	Monthly	8,400	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	600	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 12,780		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

Tuscola Health Care Center  
 0046805  
 Period Beginning 01/01/2007  
 Period End 12/31/2007

Schedule 20A

XVIII. Staffing and Salary Costs  
 Line 32-Other

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	1,883	2,123	43,930	20.69
Transportation	1,439	1,439	10,894	7.57
Home Health Aide	444	444	3,459	7.79
<b>Total Line 32-Other</b>	<b>3,766</b>	<b>4,006</b>	<b>58,283</b>	<b>14.55</b>



**Tuscola Health Care Center**

**0046805**

**Period Beginning 01/01/2007**

**Period End 12/31/2007**

**Schedule 21A**

**XIX. SUPPORT SCHEDULE**

**C. Professional Services**

<b>Vendor/Payee</b>	<b>Type</b>	<b>Amount</b>
Total (agree to Schedule V, line 19, column 3)		10,167

**Home Office Allocation**

Pearl & Associates	Legal	22
Addy Bush & Assoc	Legal	11
Registered Agent Solutions	Legal	2
Heyl, Royster, Voelker & Allen	Legal	49
Duane Morris	Legal	76
Ginoli & Co.	Accountants	2,584
RSM McGladrey	Accountants	134
McGladrey & Pullen	Accountants	204
Emdeon Business Services	Computer Services	53
Advanced Answers on Demand	Computer Services	1,432
Access 2 Go	Computer Services	108
Ivans	Computer Services	95
Kemper Technology	Computer Services	225
Adminastar Federal	Computer Services	28
Logmein	Computer Services	18
E-Health Data Solutions	Computer Services	140
Miscellaneous Vendors	Computer Services	8

Total (agree to Schedule V, line 19, column 8)		<u>15,356</u>
--	--	---------------



Facility Name &amp; ID Number Tuscola Health Care Center

# 0046805

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. IHCA-\$3,000
- (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. \$ 28,116 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. \$ 39,968  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 3,553
- (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? No 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